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ON A NEW AND PRACTICAL MODE OF GROUPING AFFECTIONS OF THE SKIN, WITH AN ANALYSIS BASED UPON ONE THOUSAND CASES.

Read before the Section of Dermatology and Syphilography, at the Forty-third Annual Meeting of the American Medical Association, held at Detroit, Mich., June, 1892.

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In a natural arrangement of affections of the skin, families should be bound together not alone by one tie, but by all possible ties, as etiology, pathology, clinical evidences and therapy. Is this the present mode? No. Consult any scheme which has ever been in vogue. One writer groups by clinical appearances—his papular affections, for example, embrace lichen planus, lichen urticatus, lichen pilaris and lichen tropicus; these four conditions have hardly anything in common, save the accident of papulation. Another writer selects the pathological process as a basis for grouping—his "exudative affections" embrace on the one hand herpes iris, and pemphigus, and on the other hand eczema. What have the first two in common with the third, other than the accident of a serous transudate? A third writer chooses anatomical seat—his "trichoses," for example, include hirsuties and fragilitas crinium. Does a knowledge of one condition furnish any aid to the comprehension of the other? Finally, a fourth writer groups on an etiological basis, and asserts perhaps that everything is either parasitic or neurotic in origin, or refers all to some antecedent diathesis, and speaks of "scrofulides" and "herpetides." He is of all investigators the nearest right, because etiology is the initial element in disease and must to a certain extent condition all the other factors. But as the etiology is by no means always determinable, his scheme must fall far short of perfection.

Now, for a classification to be harmonious, a system of averages, of compromise, is a pre-requisite. We have two families which furnish us with a model to approximate—these are the frankly parasitic diseases, due to the invasion of true skin-parasites, as scabies and tinea; and the infectious granulomata, which include syphilis tuberosa and lupus vulgaris. Members of each family may be said to resemble one another in etiology, pathology, symptomatology and therapy. We see no reason why a large number, if not all of the affections of the skin may not be grouped quite as successfully as these two families.

Let us invoke the aid of general pathology, and of all regional pathology save that of the skin; let us even invoke popular and legal phraseology. We find a universal consensus, scientific and lay, in regarding every possible infirmity of the flesh as of the nature of either deformity, injury or disease. This is popular and legal terminology, borne out by the usual scientific division of pathology into hereditary and congenital affections, effects of traumatism in the wider sense, and diseases proper, which latter alone depend upon a nexus of both predisposing and exciting causes, and thus have elements both of deformity and injury. The deformity and injury are essentially simple in their etiology, pathology, symptomatology and therapy—diseases are most complex. Assuming that the need of this threefold division is inevitable, it only remains to determine the application of such a division to dermatology. There are many who could attempt this task with much better hope of success than the writer, and it seems to us a strange thing that no one has seen fit to rehabilitate dermatology after this fashion.

A deformity of the skin implies of course far more than the average dime-museum freak, with his "alligator," "tattooed" or "rubber" integument. No one can fail to remark that a great many affections appear, either before birth or in after years, without exciting cause, without vascular or sensory disturbance, in a word without symptoms of any sort. Such affections appear just as does the hair at puberty, just as do the wisdom teeth at maturity, just as does the natural decay of the skin in senility, because inherited. In some cases an immediate heredity is evident, because blood-relatives share the affection—in other instances we are thrown back upon remote heredity or atavism for an explanation. To say that an affection has an embryonal origin, as in Cohnheim's theory of tumors, is but another way of stating that the inheritance is at fault. Affections of apparent trophic origin, whether pre-natal or post-natal, or even when actually due to nerve-lesion, stand in close relationship with embryonal anomalies. They agree in most points save etiology, and indeed it would be very difficult or impossible in many cases to decide between a true hereditary and a trophic etiology. In an anomaly of redundancy, we should naturally presuppose heredity; in one of defect, trophic influence—but there is no absolute distinction possible, since the history of heredity and of causes for dystrophy are alike often wanting, for obvious reasons.

For the sake of simplicity, we should consider with the foregoing, deformities wholly secondary to trauma or disease, as well as the alteration in the appearance of the skin which is due to the introduction of foreign pigment, whether from without or within (tattooing, argyria). Such conditions, however, differing in etiology from primary deformities, have an analogous symptomatology and therapy, and all fairly belong in the same family. Deformities, then, in the widest sense of the term, include anomalies of embryonal and trophic origin, and artificial and

acquired malformation. Pathologically, we have merely an overgrowth or an atrophy, with or without degeneration of the normal tissues of the skin. Deformities all agree in the virtual absence of symptomatology, of acute phenomena and sensory disturbance. They are virtually stationary, progressive and regressive within slight limits. As a class, they stand in no relation with any exciting cause, and when there is such, it has only a historical interest, and has no significance in the treatment. Therapeutically, the indications are very few, viz.: removal in case of redundancy, and in case of defects attempts at improving the nutrition.

We make four families of deformities: 1. Redundancies, which include simple diffuse hypertrophies, nævi and benign tumors. 2. Defects, including simple absence or atrophy, qualitative atrophy or degeneration, and dystrophy. 3. Secondary and artificial deformities, chiefly scars and stains. Finally, a fourth family is made to comprise persistent aberrations of function, presupposing that these anomalies really depend upon inappreciable deformities of structure. We refer to anomalies in the functions of vessels, nerves and glands in the skin, such as habitual flushing of the surface, hyperidrosis, comedones, etc. These conditions certainly agree with most of our notions of deformity.

It is an undoubted help to a beginner in dermatology to separate at once all the preceding affections under the name of deformity, since they are alike free from all such elements as inflammation, parasitism, systemic infection and the like. My own statistics show that deformities constitute over 20 per cent. of all affections of the skin.

Now, concerning the remaining affections, what is injury alone, and what is disease? To plunge at once *in medias res*, one may say with some truth that nearly all acute conditions may be regarded as injuries, and all chronic inflammatory or infectious conditions, including heterologous new formations, may be looked upon as diseases.

An injury has no predisposition, excepting so-called idiosyncrasy. An irritant, a single irritant alone, is all that is required to produce it, and this irritant acts upon the irritable or vaso-motor elements, in the following paths: *a.* topical irritation; *b.* reflex irritation through the hollow viscera, etc.; *c.* toxæmia, when the irritant is actually in the blood-mass; *d.* direct irritation of the centrifugal nerve of a part. To these we might add a fifth, viz.: irritation due to the perspiration. Clinically, we have either a sharply localized condition or a so-called diffuse rash. Pathologically we have, always and only, a so-called angio-neurosis, in other words a pure dermatitis, which runs a course acute and essentially self-limited, although if the injury be extreme, necrosis may result. I confess that I can see no *radical* difference between dermatitis from poison-ivy, a dentition eczema of infancy, a pemphigus from ptomaines in the circulation, a herpes zoster, and a severe lichen tropicus. I see nothing but a single irritant causing a simple dermatitis, the differences consisting only in the nature and path of the irritant, and hence in the locality and degree of the dermatitis. The treatment of the entire family of acute affections, injuries, dermatitides, or angio-neuroses, is simply the management of inflammation in general, viz.: remove the cause when possible and use antiphlogistic, protective and sedative measures.

We divide injuries according to their source into those of external and those of internal origin. The former are subdivided according as they have an inanimate or animate causation. The first named group includes dermatitis from mechanical contact of every description, all lesions from chemical and poisonous agencies, and injuries of every kind from heat and cold. Of injuries due to animate causation, there are two families. I place together from similarity in origin and pathology, all forms of cutaneous suppuration. The second group consists of the initial lesions of specific inoculable affections, including erysipelas, diphtheritis, glanders, charbon, vaccinia, chancre, etc., local affections of the nature of poison-wounds which tend to cause lymphangitis or adenopathy and to enter the general circulation.

Injuries from within include reflex affections, toxæmic rashes, neuroses and sweat-eruptions. The chief reflex disorders have the form of pruritus or urticaria; exceptionally they may be papular or vesicular, as in the reflex so called eczema of infancy, and in herpes gestationis. Reflex affections are not usually extensive in distribution, and come and go irregularly. The toxæmic rashes are a much larger family. Many of them may be partly reflex, but the general distinguishing features of this group are a period of malaise, with or without fever, the rash being critical; and the widely generalized distribution, symmetry, progressive course, and usual absence of recurrence. Here belong all rashes of specific fevers, drug eruptions, purpura, erythema circinatum, herpes iris, pemphigus, etc. Neurotic rashes occur along the tract of a nerve, and zoster seems to stand for the type and chief representative of this family. Rashes due to the perspiration include miliaria and sudamina.

Certain rashes seem to posses an indefinite faculty for relapse and recurrence. We have chronic and recurrent pruritus and urticaria, and dermatitis herpetiformis. Clinically, it is the custom to look upon these conditions as diseases, but pathologically they are merely recurrent rashes. The etiology of this group is obscure, otherwise it would be possible to give it a more definite status.

It is certainly a wise thing for the student to separate these so-called injuries from the diseases proper. My statistics show that nearly 40 per cent. of all affections of the skin belong in this division of the subject-matter.

Whatever is not included in the divisions deformity or injury is entitled to be called a true disease. Etiologically, diseases vary greatly, and cannot well be grouped from that standpoint. In general, we may say that a disease is complex, not due to a single, simple cause, such as heredity, trophic influence, trauma or simple irritation, nevertheless its etiology must be bounded by the causes of both deformities and injuries, acting in a nexus. Diseases, therefore, have both predisposing and exciting causes, and may be due to a number of irritating influences, acting upon a skin which is the seat of some deformity. Yet it is only in certain diseases that we can actually demonstrate this causal nexus, as acne juvenilis, acne rosacea and possibly others. Some diseases have an etiology apparently of the greatest simplicity, such as might seem to entitle them to be called mere injuries, yet their symptomatology and course are those of diseases in general; we mean

parasitic and professional diseases. Finally, in many diseases, we are absolutely in the dark as to etiology, and as before said, the word disease has no precise etiological signification.

Pathologically, in confirmed diseases, proliferation of embryonal corpuscles is the rule, with more or less of progressive and regressive change. Clinically, it is often impossible to distinguish, without a considerable interval of time, between a mere simple dermatitis and a disease. The *debut*, a relapse or exacerbation of a disease is necessarily of the nature of a simple injury, yet the irritant producing the dermatitis may be but a single link in the chain of causes of the disease, merely the match applied to the combustible train. Resolution does not take place, and the site of the lesion remains vulnerable to a host of forms of irritation. Practically we may take this as a rule, that when an inflammatory condition will not disappear permanently under local management suitable for simple injury, we have to do with a disease. A disease is essentially chronic, prone to relapse, and curable only through general local and alterative measures, combining the principles of the total management of both deformity and injury.

Some diseases have a comparatively simple etiology. We isolate two families: 1, diseases due to true parasites; and 2, infectious granulomata so-called. It may be claimed that such diseases should from their etiology rank only with injuries; but according to our principles, we have to consider not alone etiology, but pathology, symptomatology and therapy, and consequently we find that both groups easily take rank with diseases. Moreover, there are elements of predisposition in these conditions which must not be overlooked. Syphilis tuberosa, or the superficial gumma of the skin, the most characteristic lesion of syphilis, has in the majority of instances local exciting causes.

These two groups serve as types of two large subdivisions of diseases. 1. Type of local parasitic diseases. Here, along with frankly parasitic conditions we place diseases of a more dubious parasitic origin, such as the so-called psorospermoses, and several forms of infectious papilloma. We also place here analogous conditions due to inanimate causes, including all chronic professional affections, as corns and callus, and forms of chronic dermatitis incident to trades. Where there is some element of predisposition, conditions really simple pass on to become true diseases.

The second group includes not only such closely related conditions as syphilis, lupus and lepra, but diseases resembling them in pathology, etc., although not proven to be systemic affections—such as mycosis fungoides and rhinoscleroma. We may further add sarcoma and carcinoma, epithelioma and elephantiasis Arabum.

These two divisions of skin diseases are tolerably well understood. This is not the case with the residual affections of the skin, chiefly eczema, acne, psoriasis, etc. All of these residual diseases have been held to be due essentially to the most opposite causes. Heredity, diathesis, neurotic and trophic influences and parasites have in turn been claimed as chief etiological factors, and the results are by no means worthy of the medical progress of the past fifty years. We can only group them together as diseases of which the causation is obscure, and in which all possible factors may enact a rôle.

Let us take acne, for example. Many individuals go through life without a single comedo or acne papule. Others, while free from the disease acne, may present at times isolated erythematous spots, or papules or pustules, few in number and transitory, attributable to ingesta, indigestion, dysmenorrhœa, or other forms of reflex excitation, or simply to mechanical irritation. Now, no one would deny that just such forms of irritation must play a very important part in the genesis of true, confirmed acne; only there must be a receptive soil before the disease proper can be manifest. No one can doubt that in the case of acne juvenilis this soil is a deformed skin, the so-called coarse-grained or orange skin, tending to the functional deformity known as comedones—while in acne rosacea, the soil is a vascular deformity well described by J. Hutchinson in an article on the flushing zone of the face. But this soil is not always enough to permit a typical case of acne, even in the presence of exciting causes. There is further, in well-marked cases, that sort of debility of tissue which allows pyogenic cocci to maintain themselves and form follicular abscesses. The fact that acne juvenilis may be cured by time alone is due to the fact that the deformity at the bottom of the disease may be outgrown.

What is true of acne is probably, perhaps to a lesser extent, true of some other diseases of the skin. Time may show that certain of these diseases have a distinctively parasitic or trophic, neurotic or diathetic origin, but it is hardly likely in view of the great disparity of opinion. The various investigators are doubtless both right and wrong; in other words, all of these factors most likely enter into the causation of these diseases, but no one cause can be at the root of any disease in the same sense that the achorion Schoenleinii and bacillus lepræ are at the bottom of favus and leprosy.

It is rather a difficult task to attempt to further group these remaining skin diseases which have such complex or occult etiology. A merely mechanical subdivision is the best at present available. So-called eczema, from its frequency and variety, may stand alone. Conditions which start essentially from follicles and are limited chiefly thereto, may well form a group, which would include acne, sycosis, eczema seborrhoicum and dysidrosis. A third group could hold all the others, for while these have no very marked affinities, they are all rather infrequent, almost nothing is known of their etiology, and in a word they are grouped together because of our ignorance concerning them. Chief among them are psoriasis, lichen planus, prurigo, pityriasis rubra and exfoliative dermatitis.

In our figures, true skin diseases make up over 40 per cent. of all affections of the skin (about the same proportion as that of injuries, and twice that of deformities). In actual frequency, both deformities and injuries must greatly outnumber the diseases, on account of the universality of nævi and acquired deformities, and the great number and variety of insignificant local injuries and rashes, including the exanthemata.

We have sought to group all affections of the skin into families, the members of which should be related by the greatest possible number and variety of bonds, and append our own statistics for the past year or more, merely for illustration.

ANALYSIS OF ONE THOUSAND CASES OF AFFECTIONS OF THE SKIN.

I. Deformities (anomalies of embryonal and trophic origin, and secondary acquired and artificial malformation), 21 per cent.

A. Redundancies, 8½ per cent.

1. Simple diffuse hypertrophies, of the skin as a whole (pachydermia, dermatolysis), or of individual tissues (ichthyosis, keratosis pilaris, hypertrichosis, lentigo, telangiectasis, adenoma sebaceum, cutis elastica, etc.), 4½ per cent.

2. Nævi (nævus verrucosus, pilosus, pigmentosus, sebaceus, vasculosus, etc.), 3 per cent.

3. Benign tumors (fibroma molluscum, keloid, lipoma, angioma, lymphangioma, myoma, neuroma, etc.), 1 per cent.

B. Defects, 7½ per cent.

1. Simple defects or atrophies (congenital absence, atrophia senilis, albinismus, leucoderma, canities, alopecia, rugæ, etc.), 7 per cent.

2. Qualitative atrophies and dystrophies (fatty, granular, vitreous and colloid degeneration, xanthoma, myxœdema, scleroderma, morphœa, dystrophia cutis, etc.), ½ per cent.

C. Secondary and artificial deformities (cicatrices, striæ atrophicæ, pigmentations, tattoo-marks, coal- and powder-marks, stains, argyria, melasma from pregnancy, arsenic, malaria, etc.), 2½ per cent.

D. Functional anomalies (livedo, hyperæmia, hyperidrosis, seborrhœa, comedo, xerosis, anæsthesia, etc.), 2½ per cent.

II. Injuries (acute dermatitides, angio-neuroses, rashes and surgical affections, etc.) 38 per cent.

A. Cause external, 26½ per cent.

1. Cause inanimate (lesions of mechanical, chemical and thermal origin), 9½ per cent.

2. Cause animate (cutaneous suppurations and initial lesions of specific inoculable diseases), 17 per cent.

B. Cause internal, 11½ per cent.

1. Reflex source (pruritus, urticaria, various erythematous, papular and vesicular eruptions), 4½ per cent.

2. Toxæmic source (exanthemata, drug-eruptions, herpes iris, erythema multiforme, pemphigus, purpura, pityriasis rosea, etc.), 5½ per cent.

3. Neuritic source (herpes zoster and analogous forms), 1 per cent.

4. Hidrotic source (sudamina, lichen tropicus, etc.), ½ per cent.

III. Diseases proper, 41 per cent.

A. Local origin (parasitic and professional eruptions), 13 per cent.

1. Occupation dermatosis (corns, callus, professional eczemas, etc.), 1½ per cent.

2. Parasitic diseases (scabies, pediculosis, tinea tricophytina, favus, pityriasis versicolor, molluscum contagiosum, verruca vulgaris, verruca acuminata, verruca necrogenica, etc.), 11½ per cent.

B. Cutaneous phenomena of general chronic infectious diseases (syphilis, tuberculosis, lepra, mycosis fungoides, frambœsia, rhinoscleroma, sarcoma, carcinoma, xeroderma pigmentosum, elephantiasis Arabum), 8 per cent.

C. Diseases at present unclassifiable, 20 per cent.

1. Eczema (eczema infantile, capitis, manuum et pedum, cruris, flexuarum, orificiorum, senile, etc.), 11 per cent.

2. Diseases essentially of the follicles of the skin (acne juvenilis, acne rosacea, acne cachecticorum, acne varioliformis, sycosis, eczema seborrhoicum, dysidrosis), 6½ per cent.

3. All other diseases (psoriasis, lichen planus, prurigo, pityriasis rubra, exfoliative dermatitis, etc.), 2½ per cent.

RESUME.

Deformities, 21 per cent.; injuries of local origin, 26½ per cent.; injuries of internal origin, 11½ per cent.; diseases of local origin, 13 per cent.; diseases general in character, 8 per cent.; diseases of complex or unknown etiology, 20 per cent.

122 Euclid Ave.

THE INFLUENCE OF THE NERVOUS SYSTEM IN CERTAIN DISTURBANCES OF THE SKIN.

Read before the Section of Dermatology and Syphilography, at the Forty-third annual meeting of the American Medical Association, held at Detroit, Mich., June, 1892.

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There is no other organ of the human body where the alterations of the nervous system presiding the nutrition of the tissues produce such an apparent effect than the skin, which externally located accessible to the eye, easily shows its disturbances. The nutrition of the skin like the other organs is entirely subordinate to a certain nervous filament which regulate the tonus of the blood vessels called therefore, vaso-motor nerves. The troubles of the nutritive process of the skin clearly show the disease of the nervous element which is connected with the affected region of the skin, and they are not only the etiologic moment of the disturbance of the skin, but truly they are the effective causes. The arteries and veins are subjected to change their calibre not only in a passive way, following by the inelasticity the pressure of the blood, but also actively by the efficiency of their muscular fibers. The vasal muscles belonging to the organic system are exclusively under the control of the vaso-motor nerves, which are principally supplied by the sympathic nerve from the whole extension of the spina and also by some portion of the basis of the brain. It is well known the experiment, that when one of these nerves is cut through, the temperature of the part of the body under its influence is augmented, the arteries get swollen and the pressure of the blood is increased. On the contrary a galvanic current applied on the same nerve produces constriction in the calibre of the arteries and consequently diminution of the temperature. These facts show that the influence of the nerves on the blood-vessels is persistent and through them the muscles of the vessels are continually maintained in an active tension.

In the arteries the contractibility is much more developed than in the veins, but in the small veins and in the capillaries by lack of muscular fibers the changes in their calibre are only passive. The organic contractibility of the arteries is not in relation with their pulsation, and in consequence their contractive power is the regulator of the pressure of the blood.

The vaso-motor nerves therefore control the nutrition of the different organs by increasing or decreasing supply of the blood, according to the energy and to the activity of the organ.

The action of the vaso-motor nerves on the muscular fibres of the blood vessels explains a large number of affections of the skin which are revealed with inflammatory symptoms and changes in its nutrition functions. These affections have nothing to do with the real inflammations of the skin and in the most of the cases they are the result of some kind of trouble in the general system; very often are the result of an irritation or poisonous substance, acting upon the centers of the vaso-motor nerves. Exanthemes and many erythematous eruptions belong to this class and Auspitz called them angioneurotic eruptions, It is not this kind of skin affections, which I proposed to consider as an argument of my remarks, but I wish to speak of some disturbances in the nutritive functions of the skin, which are revealed by intrinsical alterations of its histological elements.

There is no doubt that the nerves regulating the circulation and presiding to the nutrition of the skin, have a great connection with the sensitive nerves, as often the trophoneurotic disturbances are consequence of irritation of the sensitive nervous fibres, or they are accompanied by alterations of their sensibility.

In the most of the practical cases we find that the lesions of the skin are accompanied with symptoms having reference to the nervous center. Miss V. B., of Cincinnati, a young lady twenty-two years old, for six months noticed a peculiar eruption on her body. She is a brunette, rather tall, of a good complexion, regularly menstruated, in apparent good health. When four years old she began to suffer with corea which lasted for several years. She was over with this disease, and at the age of twelve she was affected with epileptic attacks, which often repeated from two to three times a week. The epileptic attacks subsided, but it remains still now attacks of dizziness and cephalalgia which at times are repeated. The eruption consists of spots, maculæ, from the size of a dollar to that of the palm of the hand of white ivory color in the middle, surrounded by edges uniformly pinkish red. The white of the spots presents all characters of a scar, the skin cannot be pinched between the fingers, being slightly hard. The pinkish red edged are not elevated on the level of the skin, have no inflammatory symptoms, neither are accompanied by any pain or itching sensation. One spot was seated on the right gluteal region of the size of the palm of the hand, oblong, proceeding toward the hip joint. Another spot was seated on the abdomen; it begun from the right iliac region, running down to the genitals in oblique direction. Another spot, round, of the size of a dollar, was located on the middle of left thigh in its anterior region.

The young lady has no pain, no itching sensation; she complains of a kind of a numb feeling around the spots. The sense of touch on those spots is somewhat diminished. When a pin is applied on the mentioned atrophic spots, she feels the contact of the pin, but she is unable to distinguish if it is a round or sharp instrument. In the same way applying both points of a compass at a distance of one inch on the spots, she cannot say if there are two points or if there is only one, or if it is only a round instrument. Seen lately, the spots show no change, with the exception of the reddish hue of the edges, which is somewhat diminished.

This is a case of liodermia neuritica, glanzhaut, glossy skin, recently described as striæ or maculæ atrophicæ. Descriptions of this affection were given from Cantani,[1] Feré et Quermonne,[2] Touton,[3] Beuhwald,[4] Bradshaw,[5] Troisier,[6] Bouchard,[7] Wilks,[8] Sheperd,[9] and Ohmann-Dumesnil.[10] Nearly all the authors agree on this point that the origin of the striæ or maculæ atrophicæ, must be found in a trophoneurotic disturbance. Sheperd and Ohmann-Dumesnil referred to a case of liodermia consecutive to typhus and the last believes the cause of the disturbance of the skin to be the depriment action of the severe disease.

In my case it cannot be denied the nervous disease, as the lady first suffered with corea, then with epilepsy. Furthermore, the alteration of sensibility was very pronounced as shown by the numbness of the sense of touch in the affected regions of the skin. It was not allowed to me to make microscopical investigations of the abnormal skin; there is, however, no doubt that the whole affection is the result of a disturbance of the nutrition of the connective tissue of the corium causing that peculiar atropy by defect in the action of the trophic nerves.

Not less interesting I find the atrophy of the pigment leucodermia, which I found accompanied too, with affections of the nervous system. Not long ago a lady, Mrs. A. T., thirty-nine years old, rather in poor health, asked to be relieved from white spots, which she noticed on her face and on her body. The lady was of dark complexion, dark hair, very delicate and nervous, and the mucous membranes of her mouth showed her anæmic condition. Her appetite was usually not very good, and her bowels rather costive. The menstruation was scarce and accompanied with pain. She had been at several times under treatment for melancholic attacks. Often she has hysteric spasms. In this last time she noticed a white spot on her chin, on the left side, consisting of three maculæ coalescent together, each one of the size of a quarter of a dollar, from the left corner of the mouth descending toward the neck. The natural dark complexion of the lady made a great contrast with the white color of the spots. Other irregular spots could be seen on her neck, on her chest, and on her arms and hands. Of course the spots were accompanied by no symptoms whatever, no itching, no pain, no desquamation of any kind, but in those affected regions there was a great diminution of sensibility. A degree of analgesia could be detected on her fingers, a sharp needle could not produce any sensation more than something touching. The two points of a compass applied on her arm at a distance of over one inch, were not noticeable at all as two points, but they gave only the sensation of a blunt instrument touching the skin. This shows that the sense of touch was somewhat benumbed by a great diminution of sensibility in the sensitive nerves.

According to Jacob Halpern[11] the regions of the human skin abundantlly furnished with pigment show that its granules are mostly contained in the

[1] Il Morgagni, 1881.
[2] Progrès Medicale, 1881.
[3] Deutsche Med. Wochenshrift, 1886.
[4] Vierteljahresschrift für Derm. and Syph., 1883.
[5] Brit. Med. Journal, 1888.
[6] Bulletin de la Soc. Medicale des Hopiteaux, 1888.
[7] Bulletin de la Societé de Chirurgie de Paris, 1886.
[8] Guys Hospital Reports. 1861.
[9] Journal of Cutan. and Genito-Urin. Dis., 1891.
[10] Monatshefte für Pract. Dermatologie, 1891.
[11] Uder das Verhalten des Pigmentes in der Oberhaut des Mentnen. Monatshelfte für Pract. Derm., 1892.

deepest layers of the rete malpighi, and there are ramified ameboid cells which are connected with the blood vessels and the nerves. The pigment in the white race consists in small granules of yellowish dark color surrounding these ramified cells. No pigment granules are found free into the layers of the epidermis without accompanying these cells which supply the pigment. This observation affords us the explanation that when these ramified cells remain without nutrition, their protoplasma is reabsorbed and they can not supply pigment granules any more, the pigment is reabsorbed by the cells of the rete and disappears. Pigment is nothing else than the result of a chromatopoietic functions of these ameboid cells, which take the blood corpuscles or their contents, changing it into pigment which is equally distributed in the layers of the epidermis.

In the appearance of the white spots of the leucodermia, we can see some relation with the distribution of the nerves corresponding to the affected region. The neuropathic origin of leucodermia can be maintained by some analogy with lepra. In some cases of this disease we find white spots on the neck and on the limbs, and in the centre of the white spots the sensibility is remarkably diminished. Lepra affecting so conspicuously the nervous system, cannot leave any doubt that the affected nerves are the cause of the disappearing of the pigment in the corresponding regions of the skin, by the disturbed action on the blood vessels.

Another form of disturbance of the skin which I met with, and which I found connected with nervous disorders, is scleroderma. A German girl eight years old, E. S., when an infant suffered with pneumonia, cholera infantum, and her skin was affected with eczema, from which she recovered. About four years ago she began to be very nervous and restless; she could not sleep, cried without any reason. At times she was suffering with neuralgic pains in her legs and arms, and at times a severe itching sensation caused her to scratch and wound herself with the finger-nails. The parents remarked that her legs were getting thinner and the skin below the knees and calves was so hard and inelastic that the girl could walk only with great difficulty. The same changes they remarked in her arms and hands, until the girl could not move, her limbs being perfectly stiff. Itching sensations troubled the poor creature to such an extent that she could not have an hour of sound sleep.

When I saw the girl she was rather well developed, her face was looking well, showing only some freckles around her nose and cheeks. The hair rather abundant, of light chestnut hue. Nothing was to be remarked on her neck, and the body was sufficiently developed. The arms were very thin and the skin was so hard that arms and hands could not be moved. The skin had a yellowish dirty color resembling parchment from the deltoid region to the fingers of the hand. The elbow was stiff and could not be bent. It was not possible to raise a fold of the skin, and it seemed that bones, muscles and skin had formed just one mass like a piece of wood.

The epidermis showed deep furrows, and especially on the hands around the wrists were fissures from the breaking of the skin by trying to bend her hands. No movement at all was allowed to the fingers, which remained stiff in semi-flexion. The pigment was unequally distributed on the affected surface, so that the color was various, resembling a marble stone.

A large spot of sclerotic skin was on her abdomen, beginning from the left hypochondrium and extending like a bandage to the genitals, which were involved too. Both legs were in the same condition, more the right, which had lost its shape; it was stiff from the hip-joint to the toes. The left leg was affected to the knee, the thigh being nearly free. The feet like the hands were hard and stiff, with some ragades around the calf by trying to walk, which was difficult and painful. The sensibility of the affected skin was greatly diminished, to such a point of anæsthesia that a needle stuck into the skin could scarcely produce any sensation. However, the girl was suffering with itching sensations, and her skin showed some excoriations, the result of her scratching. The skin was dry and the perspiration was never remarked on her body, and was only noticeable on the head and on the face. The temperature of her body was only 97° to 97⅘°, taken under the axilla. In this case there was no doubt that not only the skin was deeply affected, but also the muscles had suffered a certain degree of atrophy, as the limbs were deformed and movements were prevented. Changes in the muscular fibres in cases of scleroderma were already found from Thibierge,[12] who expressed the opinion that the affection of the skin is only a consequence of the affection of the muscles. In our case, however, it shows just the contrary; the atrophy of the muscles seems to have been only consecutive to the affection of the skin.

I am sorry to have not been able to show any microscopical investigation of the case, on account of the objection to have cut a piece of the skin. The disease seems to have its seat in the connective tissue elements of the corium and of the subcutaneous tissue. The panniculus adiposus is completely gone by atrophy of the fatty cells, and the elastic fibers are largely increased. The blood-vessels and the lymph-spaces are compressed by the accumulation of the connective tissue elements, which produce also the atrophy of the glands of the skin.

Here we have three affections of the skin which show intimate connection with disorders of the nervous system. The first case of maculæ atrophicæ in a lady who was affected with chorea and later with epilepsy; the second case atrophy of the pigment in a lady affected with hysteria and melancholia; the third case scleroderma in a girl extremely nervous affected with neuralgic pains. I do not refer to anything new in this argument, but I want only to strengthen what has been already observed. Duhring[13] refers to a case of atrophy of the skin in consequence of alteration of the nutrition in progressive muscular atrophy. Weir Mitchell[14] referred already to cases of injuries of the nerves which caused atrophy of the skin and of the subcutaneous tissue. Robinson[15] is of the opinion that glossy skin, which is a consequence of common causes, can be also produced by inflicted wounds. McCall Anderson[16] refers to a case of atrophy of the skin which followed the injury of the supraorbital nerve, and supports the irritation of the sympaticus of the neck to be the cause of the atrophy of the half of the face. Brun-

[12] Rev. de Medecine, No. 4. 1890.
[13] Treatise on Diseases of the Skin, 1881.
[14] Injuries of the Nerves and their Consequences, 1870.
[15] A Manual of Dermatology, 1884.
[16] Treatise of Diseases of the Skin, 1887.
[17] Physiologie und Pathol. des Sympatischen Nerven Systeme, 1879.

ner[17] found atrophy of the skin of the left side of the face in an epileptic lady.

After having considered the condition of the nervous system of our patients, it appears that the cause of these disturbances of the skin, have to be found in that system. The action of the nerves is to regulate the functions of the blood vessels. The alterations seem to be especially on the sympathetic which presides over the vegetative functions, but we can not absolutely deny that the nervous centers are implicated in the production of these affections. Fibers from the brain and from the spine go through the ganglia which form the origin of the sympathetic, and make it an independent system. The fibers coming out of the ganglia are not only motor, but they are also of a sensitive nature. This is plainly emphasized when we see that an irritation applied on an organ under the control of the sympathetic causes to increase the movements of the organ supplied with that group of nerves. The ganglia are not organs of movement, but they are organs where the reflex action is accomplished without any knowledge of the brain. Any stimulus applied to the sensitive fibers, causes a reflex movement through the ganglia, the sensation remaining in it without causing any feeling. But when the stimulus exceeds the normal point it becomes an irritation, its effect does not remain limited to the ganglion, but is carried to the spine and to the brain, thus producing sensation. Many disturbances of the nutrition of the skin generally happen without producing sensation, remaining strictly limited in the jurisdiction of the sympathetic. This we see when the disturbance is not very intense, as in our case of leucodermia or liodermia, but when the results of the affection are deeper like in scleroderma, then some sensation is aroused, like in one case which was accompanied with neuralgic pains and itching sensations.

There is no doubt that some of these affections, by their topographic distribution on the skin, reminds the ramifications of the nerves laying underneath, or better, they follow the lines of division of the cutaneous nerves as drawn by Voight. In nevus line ris, ichthyosis cornea, hystrix, we find the disposition of the disease pursue the cause of the underlaying nerves. In one case of ichthyosis hystrix which came under my observation in a boy eight years old, the disease so closely followed the course of the sciatic and crural nerves in these regions of the skin that it looked as if somebody had drawn lines with the pencil. In many cases of anomalies of the pigment as in nevi pigmentarii, either congenital or acquired short time after birth, we see the lines wonderfully follow the ramification of the nerves of the affected region. Kaposi refers to two cases of nævi verrucosi, where the verrucæ were seated precisely on the course of the hyschiatic nerve.

Neumann[18] referred to a case of nervous nevus, where the pigment hypertrophy and the warts were distributed from the gluteal region to the toes of the foot in perfect correspondence with the nervous ramifications of the leg. The disposition however, of these maculæ or hypertrophies of the epidermis reminds that of the underlaying nerves. According to Phillipson,[19] the skin disturbances follow rather the cutaneous nerves maintaining the lines of Voight. The difference of direction between some lines of altered skin and the direction of the nerves, would be explained by the physical growth of the body, the affection remaining of the size as it was in infancy.

The nerves which control the nutrition of the skin are not distinct from others, but are in connection with motor and sensory filaments. In consequence of this fact, Baerensprung considered alterations of the skin of this kind the result of a disturbance of a spinal nerve. The same we can say in the nævivasculares, when the spots represent an area which recalls the nerve of the region. Nevus vascularis of one side of the face shows that originally in the embryo the trigeminus was affected and the dilatation of the capillary blood vessels was the result.

In our first case we have two areas of the skin affected with atrophy in an oblong form. It begun with a small spot of a reddish violet color, which gradually got white and atrophic in the center, showing the intensity of the color in the periphery. The intense redness was the result of stasis, due to the diminished tonus of the blood vessels, the vasomotor nerves having lost their control.

In the second case we have atrophy of the pigment following the course of the maxillary nerve inferior of one side and on the neck, breast, arm and hands of both sides.

In the third case we remarked a deep alteration of the skin affecting the corium and the subcutaneous tissue and muscles, due to the condition of nutrition of the limbs and on body.

All the three affections came recently, slowly progressing in persons affected with nervous diseases, and accompanied with nervous symptoms as anæsthesia, analgesia, hyperæsthesia.

I believe that lioderma, leucoderma and scleroderma, although different affections have great similarity between themselves. They are affections which attain people suffering with an altered condition of the general nervous system. They are the result of an affection of the nerves either central or peripheric. In one word they are the result of an alteration of nutrition of the skin by altered conditions of the trophoneurotic nerves. In conclusion I would say that the difference betweeen leucoderma, lioderma and scleroderma is only of degree, produced by lack of nutrition affecting in the first the ameboid cells of the malpighi layer which furnishes the granules of the pigment, in the second affecting the connective tissue of the superficial layer of the corium, and finally in the third involving the connective tissue of the corium and of the subcutaneous tissue.

[17] Oesterr, Jahrbuch f. Pædiatrick, 1877.
[18] Monatshelfte für Pract. Dermatologie. 1890.

MEDICINAL PLASTERS.

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In most diseases involving the skin both constitutional and local treatment is needed in order to effect a cure or improvement. Topical remedies may be applied in different forms and it is often a question whether a powder, a solution, an ointment, paste or plaster is calculated to afford most speedy relief. Plasters possess certain advantages which render them appropriate means of dealing with some varieties of skin diseases. They are especially adapted to the treatment of chronic and localized conditions. In

the subacute and formative stages of some maladies they are also of value.

Plasters are composed of mixtures which are solid at ordinary temperatures but which soften somewhat when kept in contact with the skin, to which they closely adhere. The medicated material is spread evenly upon some fine texture, very fine muslin being usually employed.

Plasters constitute an efficient protection of the diseased area against the atmosphere. Bacilli which float in the air are constantly being deposited upon the general surface, and some of these microörganisms need but a fitting soil in order to become exciting causes of disease. If, therefore, the parts are first thoroughly cleansed by a disinfectant solution the application of a plaster is an aseptic procedure. It may, furthermore, be made an antiseptic dressing by virtue of the materials which it contains. This quality not infrequently enables plasters to arrest the progress of a beginning inflammation. It enables them, moreover, to protect the affected part from a secondary or mixed infection.

A plaster maintains itself constantly in position and, consequently, the active medicaments which it contains have the most favorable opportunity to demonstrate their efficiency. When applied to properly selected cases a plaster very seldom excites irritation or aggravates the malady by the development of too much heat or by confining a discharge. If any fear of such undesirable action should arise the dressing may be easily removed every day or two and the surface cleansed with oil, glycerine, water, soap or alkaline solution. The plaster may then be reapplied. On parts in which the morbid action is sluggish the dressing may safely be left in place for several days or a week. This comparative permanence of fixation is an advantage appreciated by both patient and physician.

Plasters can be so accurately adjusted to any spot that they are for this reason a cleanly dressing. This is a virtue which every one will appreciate who has seen underwear and bed clothing soiled by the use of lotions or ointments. Their cleanliness is an undeniable convenience in precisely those chronic cases to which they are, in general, most appropriate. The fine back of the dressing also guards the surface against friction.

In consequence of the adhesiveness of plasters they can be effectively used upon portions of the body to which powders, lotions and ointments cannot be conveniently applied or maintained in position. This is the case, for instance, with the face, lips and feet. A clean-backed patch of plaster upon the face is certainly a less unsightly application than a smear of ointment. An ointment will likewise in most cases be unpleasant when rubbed upon the lip. Again, plasters are particularly beneficial in the treatment of fissures. They bring the medicament in contact with the fissure and maintain its action continuously as long as needed. They approximate the edges of the crack in such a manner as to promote repair. And as fissures are, in many instances, due to the nature of the patient's occupation, plasters prevent contact of water or other more excitant fluid with the lesion. Plasters place the borders of the tear at rest and prevent them from keeping it open for an indefinite period.

These applications exert a gentle compression which in appropriate cases has a beneficial influence upon the capillary circulation of the part. For the same reason they stimulate the absorbent vessels to remove morbid deposits.

Finally, plasters exert an influence upon nerve endings and may, therefore, be utilized for the alleviation of pain.

These preliminary considerations lead me to the enumeration of those combinations which I have with benefit employed. In connection with the description of their composition I will briefly name the conditions in which I have used the various plasters with advantage.

The basis of these preparations, the plaster-mass with which actively medicinal substances are incorporated, consists of 50 parts of india rubber, 5 parts of honey and 45 parts of soap-plaster.

LIST OF MEDICINAL PLASTERS.*

Anthrarobin.—A plaster containing 25 per cent. of anthrarobin in 75 per cent. of plaster mass is employed with success in chronic eczema, psoriasis, acne, rosacea, old syphilitic and scrofulous patches and old ulcers.

Antimony.—Antimony, 10 per cent., plaster mass, 90 per cent. Antimony plaster is a good application in indurated spots of acne and eczema, chloasma, scars and keloid.

Alum, ergot, hemlock and white precipitate.—This is composed of 20 per cent. of alum, 20 per cent. ergot, 20 per cent. of extract of hemlock bark, 30 per cent. of white precipitate and 10 per cent. of plaster-mass. By virtue of the alum and ergot which it contains, this preparation is astringent while the hemlock and white precipitate render it an excellent application when it is desirable to stimulate the absorbent vessels. This preparation checks the discharge and allays the pain of open cancer. It promotes the absorption of lupus nodules, and encourages the cicatrization of lupus ulcers. It is a serviceable plaster in scrofulous patches, enlarged glands and scrofuloderma. Its astringent properties render it valuable in hyperidrosis and bromidrosis.

Aristol.—Aristol, 25 to 40 per cent., plaster mass, 75 to 60 per cent. Aristol plaster is reliable in the treatment of scrofuloderma, lupus, tuberculosis of the skin, ulcers, chronic eczema, psoriasis, acne, rosacea and syphilitic ulcers.

Belladonna and boric acid.—30 per cent. of belladonna and 20 per cent. of boric acid are mixed with 50 per cent. of plaster-mass. The action of the belladonna is assisted by the boric acid of this preparation. It is especially appropriate to painful affections. I have used it with decided satisfaction in recurrent herpes, herpes zoster, neuralgia and hyperæsthesia of the skin. It is of service, likewise, in cutaneous anæsthesia. Local spots of pruritis are relieved by the application of this plaster. It is of utility, also, in isolated spots of erythema, of subacute and chronic eczema, in which it lessens both the itching and infiltration. This is a good plaster for use in cases of local sweating, such as excessive and fetid perspiration of hands and feet, leading to maceration of the epithelium, and a fissured and painful condition of the integument. In fissured eczema, which especially attacks the fingers and toes, belladonna and boric acid plaster is of no less value. To limited and chronic patches of vegetable parasitic disease, especially ringworm and favus, I have found

*These medicinal plasters named are prepared by Robert Young, chemist, 1000 Chestnut street, Philadelphia, Pa.

this plaster a decidedly useful dressing. The boric acid destroys the organism while the belladonna assuages irritation. In cases of inflammation of the mammary gland belladonna is particularly useful and its effect in arresting the disease and checking secretion is enhanced by the combination with boric acid. This plaster is also useful in the treatment of boils, abscesses, carbuncles, inflamed glands, burns, scalds, frost-bites, wounds and ulcers.

Cade.—Oil of cade, 25 per cent., beeswax, 25 per cent., plaster mass, 50 per cent. I have often used cade ointment with success in limited spots of chronic acne, rosacea, eczema, psoriasis and in old ulcers.

Camphor and opium.—Powdered camphor, 10 per cent., powdered opium, 5 per cent., olive oil., 5 per cent., plaster mass, 80 per cent. This is a useful combination, especially in painful affections, such as herpes, herpes zoster, and boils. It is also beneficial in burns, frost-bites, dermatitis, fissured nipples and bed-sores.

Chrysarobin.—Chrysarobin plaster contains 35 per cent. of chrysarobin in 65 per cent. of plaster-mass. It is slightly stimulant and astringent and promotes absorption. The chrysarobin is capable in a higher proportion of causing painful erythema but in the strength here cited I have not witnessed irritation from its employment. Crysarobin plaster is particularly adapted to the treatment of rebellious affections, such as psoriasis, chronic eczema, chronic acne and rosacea. This plaster is preferably kept in place for several days though it is beneficial even when it can only be applied during the night. It is serviceable in the case of old scrofulous and syphilitic spots upon the skin. Chrysarobin plaster is efficacious in the different forms of ringworm.

Elm.—Resin elm, strained, 50 per cent., plaster mass, 50 per cent. Elm plaster is serviceably applied to wounds, ulcers, bed-sores, syphilitic and scrofulous spots, acne, rosacea, freckles and chloasma.

Hydrastin.—A plaster made of 30 per cent. of hydrastin and 70 per cent. of plaster-mass, is moderately stimulant and astringent and is useful in the treatment of chancroid, unhealthy and sloughing sores, cancers and excessive secretion of the skin.

Iodoform.—This preparation contains 40 per cent. of iodoform to 60 per cent of plaster-mass. *Aristol, europhen or iodol* may often be satisfactorily substituted for iodoform. Iodoform plaster possesses anæsthetic and antiseptic virtues. It is an admirable application to chancroids, ulcerated chancres, scrofulous and syphilitic spots and ulcers, bed-sores and wounds. This preparation may be used to arrest beginning inflammation, as in boils, abscesses, adenitis and carbuncle and is beneficial in chronic ezema and lupus vulgaris.

Iodol.—Iodol, 40 per cent., plaster mass, 60 per cent. Iodol plaster is efficient in the treatment of syphilitic, scrofulous and tuberculous patches, chloasma, lentigo, scars and lupus.

Lead.—Lead plaster consists of 30 per cent. of oxide of lead and 70 per cent. of plaster-mass. It is one of the oldest and most useful preparations of this class. As a dressing in chronic eczema it serves an excellent purpose and is especially useful in cases attended by considerable thickening and a fissured condition of the skin. *Lead plaster* is often a good application, also, in subacute ezema. Erythema, burns, frost-bites and impetigo are among the affections relieved by the use of lead plaster.

Lead and opium.—Oxide of lead, 30 per cent., extract of opium, 10 per cent. and plaster-mass, 60 per cent., are contained in the above preparation. This plaster possesses the properties due to the lead and is applicable to the same cases as the simple lead plaster while the addition of the opium renders it anodyne. It is, therefore, peculiarly appropriate to the treatment of painful inflammatory conditions, such as boils, carbuncles, abscesses, bed-sores and irritable ulcers. Lead and opium plaster may be used with good effect, also, in herpes zoster, urticaria and paræsthesia.

Mercurial.—Mercurial plaster is composed of 50 per cent. each of red oxide of mercury and plaster-mass. It has a wide range of applicability. It is germicidal and sorbifacient, a cleanly and elegant application, and superior to mercurial ointment. It is beneficially applied to old syphilitic patches, to ulcers and scrofulous formations. Mercurial plaster diminishes pigmentation, and is therefore serviceable in freckles, and particularly to patches of chloasma. It is employed with benefit in lupus, acne and elephantiasis. Scars and hard infiltrated spots which result from inflammatory affections, as boils, carbuncles, sycosis and small-pox, are softened by the influence of mercurial plaster. In the treatment of many affections mercurial plaster is improved by the addition of 20 per cent. of extract of belladonna and 10 per cent. each of boric acid and extract of opium. Mercurial plaster may be beneficially applied to warts, burns, corns, callosities, chronic eczema and psoriasis. It is also used to promote absorption in enlargement of glands and joints.

M. Quinquaud has recently utilized a mercurial ointment in the treatment of constitutional syphilis. The formula of his preparation is as follows: Calomel, 20 ounces, castor oil, 6 ounces; and diachylon plaster, 60 ounces. The materials are thoroughly mixed and made into plasters four inches square. The directions given for use are that the skin is first to be washed with soap and water, after which a plaster is applied and allowed to remain upon the surface for eight days. Mercury begins to appear in the urine four or five days after the plaster is put on, and gradually increases, reaching its maximum on the eighth to eleventh day. The metal can be detected in the urine for the period of a month or six weeks. After the lapse of eight days M. Quinquaud is accustomed to have it discontinued and the skin left free for the space of eight days. This alternate use and disuse of the plaster in periods of eight days is said to entirely avoid the occurrence of ptyalism.

Oxide of zinc.—This plaster contains 40 per cent. of oxide of zinc in 60 per cent. of plaster-mass. Oxide of zinc plaster is a most excellent preparation for use in subacute and chronic eczema. It is especially serviceable in fissured conditions. Strips of this plaster are extremely serviceable in fissures of the lip caused by eczema. This plaster can be recommended in the treatment of acne spots, seborrhœa, herpes, persistent boils and obstinate ulcers.

Oxide of zinc and camphor.—Camphor, 5 per cent., oxide of zinc, 40 per cent., plaster mass, 55 per cent. The foregoing combination relieves pain and itching. It is useful in chronic eczema, especially when itching is a prominent symptom. This preparation also

answers a good purpose in erythema, and in boils and carbuncles attended with a high degree of inflammation.

Oxide of zinc and white precipitate.—Oxide of zinc, 30 per cent., white precipitate, 15 per cent., plaster mass, 55 per cent. The presence of ammoniated mercury heightens the astringency of the oxide of zinc and renders this preparation sorbifacient. It may be used with good results in cases of irritable scrofulous or syphilitic patches. It is likewise useful in chronic eczema.

Phytolacca and belladonna.—Extract of phytolacca, 20 per cent., extract of belladonna, 20 per cent., plaster-mass, 60 per cent. A plaster consisting of phytolacca and belladonna has a marked effect in reducing inflammation. It likewise promotes the repair of ulcers. Dermatitis, burns, ulcers, infiltrated and chronic patches of eczema, are relieved by the application of this plaster. The presence of phytolacca and belladonna renders it of particular value as a local remedy in mastitis. This preparation will often abort boils and inflammation of lymphatic glands if applied in the incipiency of those affections.

Subiodide of bismuth.—A plaster containing 30 per cent. of the subiodide of bismuth to 70 per cent. of plaster mass is useful. Subiodide of bismuth is not irritant, it has some local anæsthetic power, is astringent and promotes absorption. It likewise possesses antiseptic virtues. This plaster may be beneficially placed upon scrofulous or syphilitic spots. It has a good effect in freckles, chloasma and rosacea. It stimulates the absorption of inflammatory deposits, as indurated patches remaining after inflammation of the skin, orchitis, bubo and glandular enlargements.

Salicylic acid.—A plaster is made containing 25 per cent. of salicylic acid in 75 per cent. of plaster mass. It is germicidal and sorbifacient. I have found it excellently adapted to the treatment of hyperidrosis, bromidrosis, eczema of the palms and soles with thickening of the skin. It removes infiltration caused by psoriasis, boils and carbuncles. Salicylic acid plaster is a useful application in erysipelas and scrofulòderma. Dr. Hermann G. Klotz, of New York, writes that he has used with much satisfaction a plaster composed of salicylic acid, 5 to 10 per cent., petrolatum, 15 per cent., and 40 per cent. each of simple diachylon plaster and soap plaster. This, by suppressing evaporation of secretions, prevents the formation of crusts, cracking of the skin, and is useful in the treatment of rhagades. Dr. Klotz has found his compound salicylic acid plaster useful in recent vesicular and pustular eczema, and also in moist eczema of some duration, in old, infiltrated eczema, in chronic leg ulcers, syphilitic ulcers, pemphigus, lupus vulgaris and erythematosus.

Salicylic acid and cannabis indica.—25 per cent. of salicylic acid, 20 per cent. of extract of cannabis indica, and 55 per cent. of plaster mass, forms a combination which I have employed with excellent results in the treatment of corns, callosities, horns, warts, acne, rosacea, chronic eczema and psoriasis.

Salicylic acid and creosote.—Salicylic acid, 25 per cent., creosote, 5 per cent., plaster mass, 70 per cent. This is a good combination. The creasote mitigates the irritant and stimulant effect of the acid. A plaster thus composed is useful in lupus, chronic ulcers, hyperidrosis and bromidrosis.

Sulphur and chamomile.—Sulphur, 30 per cent., chamomile, 10 per cent., plaster mass, 60 per cent. In the foregoing combination the properties of both drugs are combined. Sulphur and chamomile plaster is a serviceable application in seborrhœa oleosa, papular eczema, acne and functional disorders of the sudoriparous glands.

Zinc chloride.—Chloride of zinc, 25 per cent., glycerin, 5 per cent., plaster mass, 70 per cent. This plaster is valuable in epithelioma, lupus vulgaris, and in old syphilitic and scrofulous ulcers.

In addition to the preceding formulæ, many other drugs are usefully applied in the form of plasters. Aconite, aconite and belladonna, Peruvian balsam, and soap plasters are beneficial in frost-bites. A copper plaster is efficient in local spots of syphilis, scrofula, keloid, warts, burns, corns and callosities. Witch hazel is advantageous in chronic eczema and psoriasis. Arnica, asafœtida or iron may be used in plaster form for the cure of indolent ulcers and bedsores. A plaster containing opium and iodine frequently aids removal of deep infiltrations, especially in syphilitic subjects.

Unna has introduced into dermatological practice a class of preparations which he denominates plaster-mulls. They are recommended in cases where the disease is deeply seated and the strongest applications are necessary. A layer of the medicament is evenly spread upon a sheet of gutta-percha tissue which is incorporated with a sheet of mull. In order to cause the drug to adhere both to the plaster and the skin, Unna makes use of the purest India rubber and purified oleate of aluminium. Both these substances are indifferent and unchangeable. By this method drug, plaster and skin are closely bound together. The drugs generally incorporated are mercury, carbolic acid, resorcin, salicylic acid and creosote, and oxide of zinc.

A CASE OF LUPUS.

Read in the Section of Dermatology and Syphilography, at the Forty-third annual meeting of the American Medical Association, held at Detroit, Mich., June 7, 1892.

BY W. F. BREAKEY, M.D.,
OF ANN ARBOR, MICH.

One of the purposes of this paper is to illustrate the need of delaying the report of a case until sufficient time has elapsed to have a fair and complete report.

The following memoranda of a case of lupus vulgaris, treated by Koch's lymph, May and June, 1891, with a postscript, April, 1892, are reported from notes made a year ago, as a contribution to the use of tuberculin, without comments or commendation, believing the facts to be of sufficient interest to warrant publication. Had it been reported a year ago a much more sanguine color might have been given. The inquiry suggests itself, how many of the published cures made a year ago would hold out now.

It should be stated that a case in the University Hospital, diagnosed as lupus, though not typical, had been treated for a short time with the lymph, but with unsatisfactory results, and another outpatient, with quite a typical case, was unwilling to try the treatment. I was, therefore, the more desirous to test the method in this patient, who was not only willing, but anxious to have the lymph tried.

The seat of the disease made it desirable to avoid heroic cauterization or curetting, if a method more conservative as to local treatment could be tried without risk.

The cases reported from Marine-Hospital service, under the care of H. D. Geddings, which seemed to be the most carefully conducted of any that came under my notice in this country, and free from extravagant deductions or inferences, warranted a trial of the remedy that was then so noted; and as the University Hospital had a sample of the lymph sent to Dr. Vaughan, the opportunity was offered for a fair test of the treatment. No examination for tubercle bacilli was made, as it was not deemed advisable to remove sufficient tissue for that purpose; but there was no reason to doubt the diagnosis.

My memoranda of the case are as follows:

Miss McN., age 28, fair, blonde, thin, admitted to University of Michigan Hospital May 7, 1891, with the following history: The disease first appeared on her right cheek about eight years ago, previous to which time she had been well; no lupus or consumption or other hereditary or transmissable disease in her family that she knows of.

About four years ago the disease attacked the nose, resulting after about a year in destruction and loss of part of the alæ nasi, and also a portion of the septum. It had also caused superficial destruction of skin on the right cheek. At the time of her admission there were lupus crusts on her right cheek and the end of her nose, and slight ulceration of the mucous surface in the nasal fossæ. The patient was thin and anæmic. A tentative application of an ointment of pyrogallic acid was made, followed on the 12th by ungt. zinci oxide et aristol, together with the use of ol. morrhui and hypophosphites.

The first injection of lymph, 5 milligrams, was made on the 16th; temperature and respiration normal. In eight hours temperature had risen to 102.4, pulse 120, marked local reaction. The diseased dermal tissue having a thickened infiltrated and roughened appearance, and erythematous redness extending to adjacent tissue, some burning and tingling, also a decided coryza. On the 22nd, six days later, the local reaction had wholly subsided, leaving superficial and shallower lesions, improved in appearance, and the scaling less. The second injection of 7 milligrams was used at 3 P.M., the temperature reached 103.6 in nine hours, pulse 120, respiration 28, with increased local reaction, particularly under the eyes, from effusion, and in lips, and exudation over nose and cheeks ran together. These symptoms subsided with abatement of temperature. The third injection was made on the 26th. Owing to an accidental loss, by failure of the syringe, of part of the prepared lymph, .003 was injected. Yet following this small quantity the temperature rose to 103.4 in eight hours, pulse 108, respiration 28, with corresponding local reaction. All symptoms were less intense, and subsided more rapidly, and in less than twenty-four hours, when the fourth injection was made, on the 27th, 4:30 P.M., nine milligrams being used, the largest dose injected; it was followed by the highest general and local reaction, temperature 105.4, pulse 124, respiration 32, in six hours, with more general distress, dyspnœa, cough, slight expectoration of a tenacious mucus, pain and uneasiness all over, but particularly in the chest, with considerable depression of the heart's action. Whisky, quinine and digitalis were administered. The local reaction was greater in copiousness of serous exudation, the skin of the nose looking at first almost erysipelatous, but for the roughness; and later covered with a thick yellow crust, which remained on the nose for several days. After the fourth injection the skin was quite clear, but a small pulpy tubercle on the right ala nasi, and it was thought best to test further reactions. The fifth injection, of six milligrams, was made June 5th, the temperature rose to 104.4, pulse 108, temperature, 32 in ten hours, general and local reaction less marked. Coryza came on in four hours, temperature subsided more quickly than in any former injection of full dose, beginning to decline in twelve hours more, the effusion less and rapidly subsiding. The seventh injection of five milligrams, was used June 15, 5 P.M., and on the 16th, at 10 A.M., the temperature was 100.05, at 1:30 P.M., it was 101, with the pulse 92, and respiration 20. The eighth injection was made on June 18, at 3 P.M., temperature 98.25; on the 9th, at noon, the temperature was 101, pulse 98, respiration 24. By the evening of the 10th temperature 98.05, pulse 80, respiration 20. The ninth injection was given on the 21st, six milligrams, at 8:30 P.M., temperature 101, pulse 96, respiration 22. Eleven A.M., on the 22d, temperature 99.05, pulse and respiration normal. The tenth injection was given on the 25th, six milligrams, 8:30 P.M.; at 9 A.M., on the 26th, the temperature was 100.05, pulse 88, respiration 20; on the 27th temperature 99.05, pulse 84, respiration 18.

Each succeeding injection had less reaction, and lesions on cheek and nose had all healed, although there was a slight pulpy jelly-like tubercle, but smaller than before, still remaining where it had been at the outer border of the right nasal fossi.

The point of interest is that the cure or improvement was not more permanent than has followed other modes of treatment, or none at all; and the prompt and rather rapid gain was not more marked than has followed an erysipelatous inflammation.

Afterward I made the following note: The patient was taking tonic coincidentally with the tuberculin, and upon discontinuing them the disease returned more actively. She returned to the hospital a month ago, or thereabouts, with recurrence in nearly all the old regions of disease. She has for the past three weeks had daily injections of the Gibbs-Shurley iodine liquid in gluteal region, and though no reactions occurred, the general condition improved. She is taking cod liver oil, etc., and has used pyrogallic acid locally on the ulcerating tissue. The destructive process shows marked abatement, and the general health has improved; though there is an evident outbreak in the left lower eyelid. The present condition justifies the conclusions of Dr. Geddings.

THE *Alienist* defines a consultation as "a conference with a view to joint treatment." A consultation is *not* a meeting of a practitioner to learn what he has done in a particular case and what he knows of the personal and family history of the patient. Unfortunately, this kind of meeting has been termed a consultation. Because of this muddled understanding of terms, much bitter controversy has arisen.

A CASE OF TUBERCULAR ADENITIS WITH GENERAL ALOPECIA AND PRURITUS.

Read before the Section of Dermatology and Syphilography, at the Forty-third Annual Meeting of the American Medical Association, held at Detroit, June, 1892.

BY JAMES H. DUNN, M.D.,

PROFESSOR GENITO-URINARY DISEASES, MEDICAL DEPARTMENT MINNESOTA STATE UNIVERSITY.

The following case of tuberculosis of the lymph nodes presents some phases in its clinical history which were to me quite novel, particularly the general alopecia and pruritus which during the first year of the disease were the patient's chief plague. Early in April, 1890, Dan. McA., Irish American, farmer, aged 21, fell under my observation and gave the following history: His father, mother, several brothers and sisters are all living and healthy. Of more distant relatives he knew but little, yet denied any rumor or knowledge of a tuberculous family record. He had been a very healthy and athletic young man, five feet nine inches in height, weight 185 pounds, light hair and complexion with bright blue eyes. For several years he had each autumn been engaged in "feeding" threshing machine. While employed in this very dusty work during the fall of 1888 he began to cough without expectoration, noticed marked enlargement of his cervical glands, and began to be annoyed by a terrible itching of the surface of his whole body. All these troubles were atributed to his dusty employment, but after his fall work was over, the cough and pruritus not abating, he consulted a physician, was better for a time and able to work until the fall of 1889, when while again threshing he became much worse, the pruritus especially being so intense that he came to the city and consulted a dermatologist—my esteemed friend Dr. Vanderhorck. In April, 1890, his parents sent him to St. Mary's Hospital, where he fell into my hands. At this time the lymphatic glands of the cervical and axillary regions were enlarged varying from a hazel nut to a hen's egg in size. None of these glands had suppurated nor did they in the further course of the disease show any of the usual tendency of tuberculous glands to break down. On the right side of the neck the mass of tumors was so great as to constitute a very noticeable deformity. Respiration was very labored, and an almost incessant dry barking cough plagued the patient night and day. He was incessantly rubbing and scratching. The skin was remarkably anæmic, somewhat thickened, and slightly pigmented from long scratching. There was no eruption excepting the scratch marks, most numerous upon the legs, next so on the thighs and forearms, then the arms. However the whole surface itched, and while conversing he was always engaged in rubbing the face, the scalp, or some other part. His body was almost devoid of hairs which had fallen out since this itching began. There was a very scanty and scattered growth upon parts of the scalp but absolutely none elsewhere, eyebrows, eyelashes, pubic hairs, etc., were wanting. His appetite was poor, and he was much reduced from loss of sleep. On examination of the chest by several physicians there was found to be extensive dullness over the medinastinum both in front and behind, and extending some distance to the right and left of sternum, which all agreed was due to an extensive growth or mass of greatly enlarged tracheo-bronchial glands. The spleen was not perceptibly enlarged. After a considerable study and observation of the case, I concluded that it was one of Hodgekin's disease, the pruritus and alopecia being due to pressure disturbances of the sympathetic system. As I was unable to relieve any of his symptoms, I sent him to my colleague, Dr. J. W. Bell, who put him upon codliver oil and arsenic I believe, remedies which we had tried in vain, and in less than a week he became, as he said almost a well man. The enlarged glands, reduced in size, the cough nearly cleared, the pruritus abated, he slept and ate. Of course the glandular enlargement and all the attendant symptoms had several times in the course of the disease receded and advanced, but never since the disease had been very bad had the change been so marked. He left the hospital July 11, in great hopes, though his people were informed that the respite was only temporarily. This lull in the fury of the disease lasted about one month till August, then the old symptoms all returned. I saw him no more until the post-mortem, but learned from his father and attendants that during this period of betterment his hair came in quite thick and he gained in weight several pounds. After his relapse he soon got into his old condition—incessant cough, pruritus, alopecia again almost universal, sleepless, pale, and ran along in about this condition until in November, 1890, when all his symptoms became more distressing and his abdomen and lower extremities began to swell. Abdomen was tender and painful. During the winter he failed in every way, became considerably emaciated. He died July, 1891. For some weeks before his death abdominal swelling had subsided and the legs and feet were less dropsical. Whether he had fever during this latter course which corresponded to a widespread invasion of general tuberculosis, we have no record, but during his stay in the hospital the previous summer there were no temperature disturbances.

At the post-mortem examination, held twenty-four hours after death, the following state of affairs was disclosed: The body was emaciated, lower extremities moderately œdematous, and with the exception of a very sparse growth of light hair on parts of the scalp, the body was entirely destitute of hair. The pubic, axillary and superciliary hairs, as well as eye lashes, had fallen out. There was no trace of beard and but little hair on the head. There were many abrasions, particularly upon thighs and legs, caused by scratching. The various chains of lymphatic glands were all more or less enlarged. Some of the cervical chains and the axillary on either side were of the size of a walnut. The inguinal glands were not much enlarged. On opening the chest the heart was found to be normal. The mediastinum was literally packed with a great mass of large roundish and irregular tumors, clearly a huge growth of all the bronchial and other lymphatic glands of this region. They were matted together so as to be very difficult of separation, but many were larger than hen's eggs. The pleural cavities were totally obliterated by adhesions, and the lungs were everywhere studded with tubercles the size of grains of wheat.

On opening the abdominal cavity no fluid was found, but all the organs of this cavity were adherent in one mass by more or less firm adhesions, and the peritoneum was everywhere studded with tubercles, not the finer or genuine miliary variety, but some-

what irregular bodies from the size of sago grains to small peas. So far as the eye could detect there were none of the millet seed sized, whitish-gray hard nodules sometimes seen in acute miliary tuberculosis. These were larger, softer, and more caseous in appearance. The abdominal glands were all greatly enlarged, many of them from walnut to hen's eggs in size.

The omentum was a thick, hard, nodular mass. The liver was somewhat enlarged, everywhere adherent to surrounding parts, but presented no visible tubercles in its interior. The capsule of the spleen was very thick and dense, and so intimately adherent to adjacent parts that it was extracted only after long and powerful tearing. The organ was considerably enlarged, but no tubercles were seen in its parenchyma. The kidneys were like the other organs firmly imbedded by the thickened peritoneum, but appeared normal on section. All the internal organs of chest and abdomen excepting the heart were adherent into one mass by the adhesions.

The cause of death was general tuberculosis arising from tuberculous glands.

Among the occasional sources of pruritus, I believe Kaposi and others mention lymphadenoma or Hodgkin's disease, and it is perhaps not to be marveled at that so protean a disease as tuberculosis should give rise to a great variety of symptoms. Probably no other specific infection save the syphilitic gives rise to such varied symptom complexes as the tuberculous. Outside of the pulmonary and other more ordinary manifestations, its ravages are often most curious. The autopsy is not rarely a surprise party.

SOCIETY PROCEEDINGS.

Georgia State Medical Association.

Proceedings of the Forty-fourth Annual Meeting, held at Americus, April 19, 20, and 21, 1893.

FIRST DAY—MORNING SESSION.

The Association convened in the City Hall and was called to order by the President, Dr. A. A. Smith, of Hawkinsville, at 10 A.M.

Prayer was offered by the Rev. A. M. Williams.

AN ADDRESS OF WELCOME

was delivered by Mayor A. S. Cutts, which was responded to on behalf of the Association by Dr. Mark H. O'Daniel of Macon.

The first paper read was the President's

ANNUAL ADDRESS,

by Dr. A. A. Smith.

President Smith said that Georgia had her boards of education, her boards of health, her boards of trade, and her various other boards, but she had no board of health. The sanitary condition of her 2,000,000 inhabitants, dwelling within the borders of 137 counties, should be looked after and cared for in an official way; and a board of health, composed of the best medical talent in the State should be established for that purpose. He knew of nothing that would be more conducive to the protection of the general health and prosperity of the people than the permanent establishment of a State Board of Health. He also recommended the permanent establishment of a State Board of Examination, and said no one should be allowed to practice medicine within the borders of the State until he shall have passed a rigid and satisfactory examination under this board, and received therefrom a certificate of proficiency. This would drive away quacks, and thereby not only protect the health and the lives of the people, but also the honor and the dignity of the profession. Furthermore, the curriculum of medical institutions in Georgia should be raised to a higher standard. Nothing less than the three course system should be tolerated, and each of these courses should be made broader, deeper, and more comprehensive. With a State Board of Health, and a State Board of Examination permanently established, and the curriculum of the Georgia medical schools raised to a higher standard, the profession would greatly accelerate the onward and upward progress of such a cause, and as it moved up onward and upward, higher and higher, mantled with the glory of its past, and crowned with the splendor of its future, God's truth would bloom upon its brow, and God's approbation rest upon its work.

Dr. C. C. Hart of Cross Keys, read a paper entitled

SHOT-GUN PRESCRIPTIONS,

in which he asked whether it was right to make what is known as "shot-gun" prescriptions. Personally he thought it was not right, because it increased the difficulty of prescribing, and made the therapeutic action of medicines more uncertain and consequently less safe for the patient. We should strive to make medicine an exact science, which we could never hope to do without exact knowledge, and how are we to know what effect a certain medicine has when it is combined with several other medicines, some of them perhaps of an antagonistic nature?

Dr. J. I. Darby of Americus, contributed a paper entitled

PUERPERAL SEPTICÆMIA AND ITS TREATMENT.

FIRST DAY—AFTERNOON SESSION.

The first paper read was by Dr. J. M. Head of Zebulon, entitled

PUERPERAL ECLAMPSIA WITH A REPORT OF CASES.

True eclampsia might differ from epilepsy clinically, but the paroxysms of each were essentially the same. We find in eclampsia occasionally premonitory symptoms which, if properly interpreted by the obstetrician, will put him upon his guard and sometimes enable him to ward off the attack. However, in a considerable number of cases the symptoms are so slight as to escape detection, and suspicion is not aroused until severe convulsions are on. Hence we find it is of practical importance to bear well in mind the most common of the symptoms which are associated with cerebral troubles, such as severe headache, either general or unilateral, spots before the eyes, dizziness, blindness, vertigo or impairment of the intellectual faculties, which are occasionally observed. Again, we see symptoms manifested in restlessness, irritability of temper, stupor, general indisposition, œdema of the cellular or subcutaneous tissue, shown by swelling of the lower extremities, but this one symptom bears with it a much more serious import when it is observed as occurring in the upper extremities or a swollen face. These symptoms are sufficient to excite the most serious apprehensions and lead us to make examinations of their causes.

So eclampsia should be considered of a functional nature through reflex influences, as chorea is an occasional feature of pregnancy. For the purpose of elucidation the speaker mentioned the prominent disorders of the pregnant stage.

CONTAGIOUSNESS OF CONSUMPTION.

Dr. J. G. Hopkins, of Thomasville, read a paper on this subject. The speaker said he had joined the growing army which placed tuberculosis in the category of contagious diseases, and his experience with this disease during nineteen years of investigation in Thomasville—which place is a

resort for consumptives—bore him out in his opinion, and made him a willing subject of the great and erudite Koch. He does not doubt but that all men, women and children at some time or times receive into their air passages, the tubercle bacilli, but fortunately the great majority possessed the power of repelling them and throwing them off; they did not find that soil, so to speak, which is adapted to their growth. Indians in a state of nativity seemed impervious to the germs of consumption, but were now dying by thousands on the reservations. The whites and the blacks in prisons and asylums all over the world labored under similar conditions. A report from the Illinois State prison at Joliet says that there are 1,400 convicts within the walls, and fully one-third of them have consumption in a light or bad form. Nearly all deaths of persons in the penitentiary have been caused by consumption.

Dr. Hopkins emphasized the danger that lurks in sleeping cars, in carpets, bedding, clothing, and in the walls of apartments occupied by consumptives, which have not been properly renovated and rendered harmless by antiseptic measures.

Consumptives should be forced to provide for the destruction of sputa. Whenever situated so as not to expectorate directly into a germicide or the fire, they should use some means of conveying the sputa to the germicide or the flames. If handkerchiefs or cloths are used, they should not be sent to the laundry as human happiness and life are jeopardized through the probability of inoculation through abrasions upon the hands. These bacilli should never be allowed to dry up and impregnate the air, as is now done through ignorance of possible result. Numerous experiments by leading medical authorities have proven beyond doubt that consumption is an inoculable disease, and so rapidly is the throng of converts growing that the speaker would not be surprised, if, even in his day, resorts now soliciting the patronage of the consumptive will be quarantining against him.

Dr. J. MacFadden Gaston of Atlanta, read a paper entitled

SCIENCE IN MEDICINE AND SURGERY.

He said at this time the medical profession was undergoing a most interesting transition from the extreme views which had been held by some in regard to the employment of germicides in surgical practice. There was a time within the past decade when it was deemed to be scientific and progressive to use antiseptic measures of the most energetic kind in all operations, whether there was a septic element to combat or not. But, thanks to the mature investigation of the effects of germicides upon normal structures by bacteriologists for this class of work, it has been demonstrated that the so-called antiseptic agents are capable of setting up septic processes in healthy tissues. The tables are now turned, and instead of a surgeon being compromised by eliminating germicides from his surgical procedures in ordinary cases, and confining his irrigation of recent wounds to simple sterilized water, it is he who departs from this course by the employment of solutions impregnated with toxic agents who is held responsible for the consequences of their absorption. In case there is a healthy and normal state of structures involved in a cutting operation, there can be no indication for antiseptics, and their use is only calculated to do harm by absorption, and the best men in the profession have ceased to employ them. The most energetic and hence the most likely to cause mischief is corrosive sublimate. Dr. Gaston quoted Dr. Vance of Louisville, as saying that "it was beyond all doubt that the present position of bichloride was rather against its use, and that it did more harm than good," as demonstrated by Welch and Abbott.

Dr. Mark H. O'Daniel, of Macon, read a short paper on

MULTIPLE NEURITIS, ALCOHOLIC,

and reported a case. The patient was thirty-six years of age, fleshy, short build, short neck, florid complexion, a bilious temperament, and a book-keeper by occupation. The patient had taken but little exercise for quite a long while except in the elbow joints. He came of a nervous ancestry, an aunt having died of climateric mania, and other relatives who had been insane for a short time, showing beyond doubt a predisposition on part of the patient to nervous trouble, which if it had not existed, the use of alcohol might not have precipitated the disease in question. The patient drank from one to two quarts of whisky a day, that is, during twenty-four hours. He had all the symptoms of such cases. Under appropriate treatment the patient made a good recovery.

Dr. Willis F. Westmoreland of Atlanta, followed with a paper entitled

SYPHILIS FROM A SOCIOLOGICAL STANDPOINT,

in which he said year after year, particularly in the clinics, syphilitic subjects, a great many of them women, came before him suffering from this disease in all its stages, from the original lesion to the worst ravages of the second and tertiary stages, with mucous patches and syphilitic ulcers covering them. And when he found upon investigation, many of them servants, occupying various household positions as chambermaids, nurses, cooks, waitresses, etc., he could not but think that God protects the families exposed to the baleful contamination of their service, and particularly the poor little defenseless ones whom they nurse, and with whom their relations are so intimate. Any one who has not investigated the subject will be overwhelmed with surprise at the number of cases acquired otherwise than by sexual intercourse, and the various means by which it has been transmitted. Physicians and dentists are themselves exposed, and likewise expose their patients to these dangers. Thousands of physicians and midwives in the practice of their calling, in examining and operating on syphilitic subjects, or by post-mortem, are exposed. Dentists by having their fingers scratched against a rough tooth or instrument, while working on a patient whose mouth is filled with mucous patches. On the other hand, many more patients are infected by the carelessness of physicians.

APRIL 20, SECOND DAY—MORNING SESSION.

Dr. W. H. Elliott of Savannah, addressed the Association on

ELASTIC CONSTRICTION AS A HÆMOSTATIC MEASURE,

his remarks being a review of Senn's method. He said the Association was familiar with Esmarch's method, which consisted in putting on an elastic bandage from the periphery slowly and gradually, so as to empty the limb of blood, putting it on up to a point just above where the surgeon is going to operate. He then puts on a narrow elastic band at that point, so as to cut off the circulation from the limb entirely, then removing the compression bandage to go on with the operation, which he had fitly called "a bloodless operation." Esmarch was not the inventor of the bloodless operation, but surgeons were indebted to his genius for improving its technique and for making this established method a popular procedure in surgery. The speaker then stated the two grave objections against the method as used by Esmarch, as advanced by Dr. Senn. The first objection was that forcible compression of the blood out of the tissues by an elastic bandage was liable to send into the surrounding tissues the elements of microbic and malignant diseases. Cancer cells may thus be scattered and disseminated through the system, or the cells of pus or

of tuberculosis might be sent abroad to do damage elsewhere. The second objection raised was that the constricting of the limb with a tube or a narrow bandage at one point was liable to do injury, first to the muscle, and secondly to the nerve. Dr. Elliott had used Esmarch's method as modified by Dr. Senn with great satisfaction.

Dr. O. H. Buford of Cartersville, reported a rare case in obstetric practice, showing hour glass contractions on fœtus.

Dr. W. P. Williams of Blackshear, read a paper entitled

PERSISTENT REMITTENT OR SO-CALLED TYPHO-MALARIAL FEVER.

The author gave an analysis of a few cases of persistent remittent fever, touching its diagnosis and differential diagnosis from typhoid fever especially. He presented the clinical side of the matter, as his investigations extended no further. He presented three forms for consideration: *First*, the abortive form, or such as are immediately amenable to treatment. *Second*, the continued form with low temperature. *Third*, the continued form with high temperature. Under the first form he was called to see the case of a negro that had been sick about a day. He found a temperature of 106°, no other striking symptom. He gave him fifteen grains of quinine, and left two other doses to be repeated at six-hour intervals. His diagnosis and prognosis were persistent remittent fever, with the prospect of a long siege. He returned the next morning, and found that the patient was up and gone.

The value of a diagnosis between these maladies was apparent when we came to the subject of treatment. The treatment which the speaker had followed, which had proven reasonably successful in persistent remittent fever, was the anti-malarial preparations, principally cinchona and its derivatives, and arsenic, with cholagogue cathartics (most frequently calomel) at stated intervals, applying other medicines as they were indicated. This treatment, while very beneficial in a large number of malarial cases, he would consider utterly useless and even dangerous in applying it to typhoid fever cases. The author closed his paper by saying that for every degree in rise of temperature there was a corresponding increase of heart action from eight to ten beats. In several of his cases of this fever this ratio was completely destroyed, and in some the reverse took place.

Dr. M. L. Currie of Mount Vernon, read a paper entitled

PERIPROCTITIS WITH AN ABSCESS AND REPORT OF A CASE.

He said periproctitis was one of those infrequent inflammatory diseases which the general practitioner might at any time be called to treat, and which he might fail to recognize until much damage to his patient ensued. It is usually suppurative in character, but a cure may be effected by absorption, even after a distinct tumor is formed. Of the cause of the disease but little can be said. It may result from traumatism, foreign bodies, extension of adjacent inflammatory processes, or any structural disease involving the mucous membrane of the rectum. The manner of its extension and the course of the morbid processes excited, are identical with those seen in perityphlitis following typhlitis. The prognosis depends much upon the time when a diagnosis is made, the treatment of both the inflammation and the abscess, as well as the physical condition of the patient. When the vitality is low, and the abscess high up in the pelvic cavity, or when the patient is tuberculous, it is unfavorable; when otherwise, we may hope for recovery. The author then gave the diagnostic symptoms and the treatment in connection with the case he reported.

Dr. R. R. Kime of Atlanta, followed with a paper on

ECTOPIC PREGNANCY, ITS PATHOLOGY, SYMPTOMS AND TREATMENT.

After dwelling upon the pathology and symptoms, the author summarized the treatment as follows:

1. In primary or secondary intra-peritoneal rupture of ectopic sac, operate by cœliotomy at once.

2. Before primary rupture with diagnosis of tubal pregnancy, extirpate cyst, tube and ovary. Fœticide for this condition by electricity and morphia injections are but temporary expedients, suitable for cases of doubtful diagnosis, or where a competent operator can not be obtained. Their use only allures patients into a false hope of security when delay is dangerous. If diagnosis could be made in first three or four weeks of pregnancy, then electricity might accomplish more potent results.

3. With extra-peritoneal primary rupture into broad ligament in early weeks of gestation, producing pelvic hæmatocele, wait for absorption of effused blood; if it fail, then perform cœliotomy or vaginal drainage.

4. If child survives primary rupture of tube into broad ligament, do not commit murder, keep a clean conscience toward God and man, let fœtus live, keeping patient under strict observation, ready to operate at any time when life of patient demands it, or fœtus has at least reached a viable period. By waiting for development of fœtus and cyst as Tait claims, the peritoneum is pushed up on the side in which they are located, so that in later months of pregnancy a lateral incision will enter cyst, and fœtus may be extracted without entering abdominal cavity.

5. Surgical interference should be the rule in all cases of ectopic pregnancy reaching full term, even after spurious labor and death of fœtus.

Dr. Luther B. Grandy of Atlanta, read a paper entitled

A BOARD OF MEDICAL EXAMINERS; THE STATE'S MEDICAL DUTY.

in which he suggested the advisability in November last of taking steps toward the establishment of a board of medical examiners in Georgia. The question under discussion was one which touched every home in Georgia, into which sickness or accident would surely come at one time or another. There were two classes of so-called doctors from whom the people of this and every State need to be protected. One was the ignorant practitioner without capacity, the other was the unprincipled charlatan without conscience. The absence of such a board and the fact that a diploma was a license, was but throwing down the bars to all the incompetent and fraudulent who were being rejected in other places. And here was the point of the matter which was of the most interest to physicians, because it had such a bearing upon the *personnel* of the profession of the State. If the medical profession in Georgia was to be made up largely of those who had been refused by other States on account of incompetency or dishonesty, then it was time we were entering our protest at once. There were about 2,700 physicians in Georgia, and still they came, and all were welcome. None were ever rejected. By a reasonable estimate about 700 of these would have been declared unqualified in other States. There had been nearly 400 rejections by the Virginia and North Carolina boards within the last seven years. What became of all those persons who were examined and declined by the boards of New Jersey, Virginia, North Carolina, Florida, Alabama, Illinois, Minnesota and other States? Our neighbors, Alabama, South Carolina and Florida, have rejected respectively 20, 29 and 30 per cent. of their applicants. Where do these people go? As for the quacks, when driven from one place they quickly take refuge in another. They change their sky but not their affections (*cœlum, non animum, mutant*). Like other moving bodies

they travel along the lines of least resistance until they find some place still willing to receive and patronize them. Dr. Grandy closed by saying that if Georgia would like to divorce the right to practice medicine from the empty honor of having a diploma; if she would like to bring about higher standards in her medical schools and stimulate her students to higher aims; if she would like to improve the *personnel* of the medical profession in the State and endeavor to make it what it should be, an intelligent, honest and conscientious body of physicians; then let there be established a Board of Medical Examiners who shall be untrammeled of any college connections, and who shall determine whether a given applicant is qualified to practice medicine in Georgia.

Dr. Arthur C. Blain of Macon, contributed a paper entitled

THE PRACTICE OF MEDICINE IN GEORGIA.

He called attention to the want of laws governing the practice of medicine in the State. He also emphasized the importance of creating a State Board of Medical Examiners. Georgia was made a dumping-ground for all who failed to pass the requisite examination to obtain a license to practice in Virginia, Florida or Alabama. State Boards not only afforded protection to the people from charlatans and unqualified practitioners, but exerted a salutary influence towards elevating the educational standard of the medical profession. The speaker recommended that a committee be sent to Atlanta during the next session of the legislature to assist in formulating and passing some good law that would meet the requirements of the case.

Dr. J. C. Avery of Atlanta, followed with a paper on "State and Municipal Hygiene."

The three papers were ably discussed by Drs. C. D. Hurt, R. O. Engram, Willis F. Westmoreland, W. H. Elliott, F. W. McRae, M. B. Hutchins, and a committee of one from each congressional district appointed for the purpose previously outlined.

SECOND DAY—AFTERNOON SESSION.

Dr. C. D. Hurt, of Atlanta, read a paper entitled

ETIOLOGY OF PUERPERAL ECLAMPSIA, ITS TREATMENT, WITH REPORT OF SOME TYPICAL CASES.

After a careful study of various authors and summing up his observations and experience at the bedside, the author felt warranted in offering the following conclusions: 1. That eclampsia gravidarium in every case is the result of some influence which is directly or indirectly exerted upon the nervous system, causing a derangement of its functions. 2. That such influences may exist singly or be coöperative, and that such influence may be direct violence or mechanical pressure. 3. That one or more of these influences may reach the nervous system by absorption or through the circulation. 4. That by chemical changes wrought under certain conditions in the system, toxic elements may be created and proved deleterious. Again, certain elements are harmless as they exist in normal proportions in the constitution, but exert a toxic influence in abnormal quantities. Urea as a toxic element abnormally increased by retention in the system, is assigned by many as the most frequent cause. Yet there are some who do not hold to this opinion. All admit that eclampsia and uræmia coexist in a very large per cent. of cases, while they disagree as to their relation of cause and effect. Furthermore, all admit that uræmia can not be found to exist in every case of eclampsia, therefore, other causes than uræmia can and do produce eclampsia. That in every case irritation may and does exert an influence which materially aids in bringing on a seizure, and that in many cases this irritation, intensified by protracted labor, hard pains, unyielding os and exhaustion of the nervous system, develops eclampsia. That a plethoric condition of the patient, full habit, distended blood vessels, increased susceptibility to an apoplectic condition and excessive irritability, and that with this plethora a crowding of the blood into the lungs and upon the brain materially interferes with the functions of the nervous system. That the emotional system is not silent in some women, and that it helps to precipitate a fit.

Dr. H. McHatton of Macon, read a paper entitled

FOUR WOMEN WHO REFUSED OOPHORECTOMY AND THEIR SUBSEQUENT HISTORIES.

The author gave a brief *resume* of the histories of the only four women that he had ever known who refused the operation. The time that had elapsed since it was advised varied from eighteen months to twelve years. The speaker made the point that in each case the operation was advised and urged by gynecologists of standing both North and South, consequently they must have been convinced that they were cases demanding operative interference. In a practice of twelve years he had had occasion to recommend the removal of the appendages once, excepting cases of ovarian tumors, and that one proved to be a case of pyosalpinx. Several of his patients had drifted into other hands and had oöphorectomy performed, and as far as he could learn had been disappointed in the results each time. The best men in this special line of work were doing the operation less and less each year. Their place was being amply filled by lesser lights, with smaller numbers of individual cases, but with a yearly aggregate that is terrible to contemplate. By what combination of circumstances could one man, to fame unknown, in a small interior city, and in a short space of time, find 144 cases demanding abdominal section?

Dr. C. H. Peete of Macon, contributed a paper on

PARTIAL TENOTOMY, A RADICAL CURE FOR HETEROPHORALGIA.

The author finds that the majority of cases suffering from heterophoralgia are those of young adult life, or that they have been sufferers since that time. He accounts for it by the fact that we know in order to cause it the patient must concentrate his vision on an object, and the length of time of this concentration governs the intensity of suffering. In children the vision is never fixed on any point for a length of time, consequently the symptoms are not brought on. In young adults who have acquired the habit of hard study and constant close work, it occurs frequently, and we will find in most cases that it commenced with the time of their beginning to work or in a very short time after. The muscle tests should be applied to every case that came to the oculist for refraction work, and when he finds these deviations existing, he should resort to the radical relief, partial tenotomy.

Dr. F. W. McRae of Atlanta, read a paper entitled

STONE IN THE BLADDER, WITH REPORT OF CASES.

He dealt with the etiology, symptomatology and treatment of stone in the bladder, purposely avoiding extensive details and references to authorities. The chief predisposing causes were defective digestion and assimilation, due either to improper diet, to a preponderance of solid over liquid ingesta, or to too high living coupled with insufficient exercise and imperfect oxidation. There is an excess of the solids of the urine. These are only predisposing causes, and others such as mucus, pus, etc., due to inflammatory conditions of the urinary mucous membrane, must be present before stone in the bladder will result. A history of nephritic colic not followed by the expulsion of the gravel through the urethra, would naturally lead us to suspect the formation of stone in the bladder when followed by irritation of that viscus. Only when the stone can be felt by the

searcher and the characteristic click elicited are we sure of the presence of calculus in the bladder. In one of the cases which the author reported the symptoms were characteristic of stone in the bladder, although no stone was found The operation was a brilliant success in relieving the patient of a most violent cystititis of long standing. The author then dealt with the methods of treating stone in the bladder, and said that no method had so wide a range of applicability and as low a death rate as litholaopaxy (Bigelow's operation). He had had, however, no personal experience with it, as the cases thus far presenting themselves to him were such as might be best treated by other procedures.

This operation offered much the best results except in very young children, very large or very hard stones, or where there was coëxisting tight organic strictures or enlarged prostate of such character as to prevent the introduction of the lithotrite, or where there was a violent cystitis associated with stone. For large stones associated with prostate or vesical tumors the high operation was undoubtedly far superior to the perineal operations. Small stones associated with stricture of the deep urethra or violent cystitis were best treated by the median operation. Nor was the lateral operation to be entirely set aside for the now more popular operations of litholaopaxy and suprapubic lithotomy. Each of these operations had its proper field of usefulness, and it was only by a careful selection of the methods of treatment that the best results were to be obtained.

Dr. W. R. Googe of Abbeville, reported a case of fracture of the skull, with protrusion of the brain substance and removal of same.

THIRD DAY—MORNING SESSION.

Dr. J. B. S. Holmes of Rome, read a lengthy paper on

THE TECHNIQUE AND AFTER-TREATMENT OF OVARIOTOMY.

The author offered the paper as an *exposé* of the methods adopted and successfully used by him in his abdominal work. He submitted the paper with the earnest hope that it might elicit a full and free discussion from all those interested in this line of work. By such discussions our methods may be compared and those adopted that promise best results to our patients. No one could truthfully say that in every particular his method was the best. While we might in the main agree, yet upon slight and seemingly indifferent details might hinge the successful issue of our cases. He stood ready and willing to take up any suggestions, from his brother surgeons, if he could get better results by so doing. The author then took up each step *seriatim* of the technique and after-treatment.

Dr. Frank M. Ridley of La Grange, then delivered the Orator's Address. He selected for his subject "Woman's Relations to the Practice of Medicine."

Dr. M. B. Hutchins of Atlanta, contributed a paper entitled

MECHANICAL TREATMENT OF SOME SKIN ANOMALIES.

The author dwelt upon some of the various mechanical means of removing anomalies of the skin. The destruction of superfluous hairs, of moles, birth-marks, and the various simple growths of the skin were described. In 1879 Dr. Michel of St. Louis, successfully employed electrolysis for the destruction of the hairs in trichiasis. Dr. Hardaway, a dermatologist of the same city, followed the idea in the treatment of hypertrichosis. Various dermatologists had since reported upon its successful use. Hair upon the lip and face of women afforded the usual field of operation. Three to eight cells of a galvanic battery were used. For the past two years Dr. Hutchins had used some "Law" cells put together by himself containing as the fluid an aqueous solution of sal ammoniac. For the destruction of hairs five of these were sufficient, though they had not been filled in two years. Seven of these cells sufficed for ordinary moles. To the negative pole a pencil-shaped needle holder containing a number eight or twelve ordinary sewing needle is attached, while the positive pole is provided with the usual spone electrode. The needle is attached to the negative pole for the reason that electrolysis through the positive will leave a black dot at the point of insertion of the needle. The author prefers the needle holder having a spring for opening or closing the circuit, as this leaves the entire control of the circuit to him, the patient steadily holding the well-wetted sponge electrode in one hand instead of having to open and close the circuit by letting go or catching hold of the sponge. The needle is carefully inserted into the hair follicle, parallel to the root, until slight resistance, the bottom of the follicle and the seat of the hair papilla, is felt. The circuit is then closed and the current allowed to pass until a frothy substance the size of a small pin head fills the follicle, and a small area of blanching appears around the needle. If the needle has followed the course of the hair root and remained in the follicle, the pain is less than when the root sheaths are pierced, and the frothy substance is more abundant. If the hair is easily pulled out it is reasonably certain that there will be no regrowth, but if it pulls out with difficulty or breaks off, the current must be immediately reapplied. A pair of forceps made for the purpose are used to extract the hairs.

Dr. Hutchins then reported several interesting cases which he had treated successfully by electrolysis.

The following officers were elected:

President, Dr. W. H. Elliott, Savannah; First Vice-President, Dr. G. T. Miller, Americus; Second Vice-President, Dr. H. McHatton, Macon; Secretary, Dr. Dan H. Howell, Atlanta; Treasurer, Dr. E. C. Goodrich, Augusta.

The next annual meeting of the Association will be held in Atlanta.

DOMESTIC CORRESPONDENCE.

Revision of the Code of Ethics.

To the Editor of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION:

Dear Sir:—THE JOURNAL of April 22 contains a letter typical of the views of those who desire the abrogation of the Code of Ethics. It would be a waste of time to further review the specious pleadings of the pseudo reformers whose propositions tend so clearly to retrogression and to immoral practices of many kinds. It suffices to say that no better evidence that the Code does not need revision could have been adduced than by the letter in question. That there is great need of the stringent but wise provisions in such cases as advertising, of patenting appliances, etc., by physicians is rendered more evident from the condemnation of the related sections by those who wish to violate the Code, and who, for this purpose, demand the sanction of the profession.

The frequent assertions by dissenters that the Code is verbose, that its language is antiquated, that its provisions are useless and inhuman, that it is not in accord with the spirit of the age, and that it is a dead letter, show the extreme weakness of their cause. Their indulgence in harsh and improper language is another evidence of a bad cause. They do not seem to realize that invectives are not arguments, that accusations are not proofs, and that assumptions are not demonstrations. They have been repeatedly challenged to argumentation, but they have uttered nothing bearing the least semblance of an argument. They have absolutely failed to show cause why the Code should be altered.

If the reader takes pains to study Dr. Flint's commentaries on the Code, published by D. Appleton & Co., of New York, he will find an ample refutation of each and every objection stated in the letter to THE JOURNAL of April 22. The Code, based as it is on the maxims of many sages, was written for all time, and the teachings it inculcates can be condemned only by evil-doers. Its admirably pure and exact language gives it a particular charm which delights the scholar, and serves as a model of excellence for the rising generation of medical writers. Therefore, let the misguided members who are striving to destroy this monument of the wisdom of good and true men pause and reflect before taking final action; let them examine the Code diligently, maxim by maxim, section by section, sentence by sentence, word by word, and let them frankly and honestly say if they find an expression which can justly be condemned; if not, let them cease their unbecoming agitation, and employ their best thoughts to further the interests of science and of the Association whose laws they are pledged to obey as a condition of membership.

A CONSERVATIVE MEMBER.

TO THE EDITOR OF THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION:

Dear Sir:—We are glad to hear a nineteenth century voice from California. I, for one, can honestly concur in what he has written, living as I do near a medical center of some importance. What can we lesser lights do when the president of one of the best (if not the best) colleges in the State can trephine a case for a homœopath? Another who is a professor in the same school, and has had the honor of being chairman of one of the Sections of the American Medical Association, sending a nice little note to the dean of the homœopathic department of the University of Michigan, "who is a good friend of his," concurring in his opinion and advising him to follow the plan he recommended.

Another professor holding an important position on last year's committee of the American Medical Association, having a peculiar case with Dr.——whose sign reads Dr.—— eclectic physician, etc.

Now the point I wish to make is this: Is it not unjust to keep the younger members to the Code, so that professors and presidents can get all the regular graduates' patients needing special treatment, and scoop in the irregulars also?

These instances are but as a drop in the bucket as regards the respect to the Code in this State.

FAIR PLAY.

To the Editor of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION:

Dear Sir:—The "Code" question is admirably epitomized in two letters published in THE JOURNAL of April 22.

A correspondent writing from San José, Cal., with evident sincerity advances in effect the following argument: "The Code is daily violated by men apparently respectable; *therefore*, the Code should be repealed."

In this benighted commonwealth of Pennsylvania, Mr. Editor, when, not long ago, men high in political station and prominent in the church were found to be guilty of forgery and embezzlement, we did not either strike out the eighth commandment from our copies of the decalogue, or repeal the criminal code of the State. We sent the highly respectable criminals to the penitentiary.

While among those opposed to certain provisions of the Code or to any code, are many who are actuated by the highest motives, I fear that all who shelter themselves behind these pure-minded men are not equally unselfish. As to these latter, "A Kentucky Member" hits the nail squarely on the head. Even if the Code should be repealed, he intimates honorable physicians "intend to keep it in spirit and letter. If it does not suit others, we pity their depravity and hope they will leave us alone, and 'roost' with their own kind." That sums up the situation.

One other point seems pertinent. Many members are under the impression that the reports of the committees on Revision of Constitution and Revision of Code, are to be finally acted upon at Milwaukee. Article VII of the Constitution of the American Medical Association, however, provides that propositions to amend or alter shall be made at an annual meeting and be acted upon at the following annual meeting, a three-fourths vote being necessary for adoption. A recommendation to revise is not such a specific proposition to amend as is contemplated by that article; and hence, the reports of the committees will have merely the same parliamentary status, as a proposition to amend made by an individual member. They can be submitted at Milwaukee but cannot be legally acted upon until the following meeting.

Most respectfully,

SOLOMON SOLIS COHEN.

Philadelphia, April 24, 1893.

TO the Editor of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION:

I presume that much valuable space in your JOURNAL will be wasted in discussing the revision of the Code. Allow me to waste a little in commenting upon Dr. A. C. Simonton's article in the April 22 number of THE JOURNAL.

The Doctor says twice in his communication that the *old Code is harmless.* Now, this is saying more for it than can be said of any article you have published condemning the Code (your editorial on Professional Unity to the contrary notwithstanding). The Doctor objects to flagrant violations of the Code. Especially to the *free* dispensaries, medical colleges and hospitals, and intimates that if the "old dilapidated, antiquated, ancient relic of ignorance and superstition" Code was enforced it would *save the profession thousands and millions of dollars annually.* If this is true, and I do not doubt it, why should the profession be in any hurry about changing the Code, much less to give it up entirely? A harmless code that will save the profession thousands and millions of dollars annually, it seems to me is just the kind of a code we need.

The Doctor would like a code which would allow specialists special rights, forgetting that knowledge acquired in any special branch does not alter the relations that physicians sustain to each other; because A or B is more expert in the use of instruments, or better posted in the treatment of cancer, or has a position higher than C, he is not privileged to herald this superior qualification to the world through the columns of newspapers. According to the Code, this would be quackery, and I think, yes, I know that the "*respectable specialist*" who does this is a quack, however respectable he may be. "Equal rights to all and exclusive privileges to none," may not be a medical axiom, but it is a very good rule to apply to the profession. Respectable specialists and those who violate the Code can not be put in the same class; letting both into the same organization would not change their characters. The violator would keep up his evil practices, and a code that tries to unite quacks and physicians will be a dead code. Now, a word or two in regard to the proprietary man. The old Code men have no use for him (earthly). The true physician does not allow the charlatan to do the diagnosing and prescribing while he plays nurse. It is possibly an easy way to practice, but the sticklers for the old Code do not see fit to adopt this plan. We look upon the proprietary man as using borrowed glory; all his knowledge is borrowed except that which he uses to mislead the profession. Now does he know anything about the etiology of disease and when his nostrum is indicated? He has seen several medicines recommended

for a certain malady, and he imagines if they were all mixed and administered at the same time they would certainly cure; therefore, he makes his combination, sends a sample of it to some credulous doctor, gets his certificate, repeats this for a few weeks, and then he is ready to astonish the world with his wonderful achievements. He takes advantage of men in high position, and publishes their names in his circulars and fly sheets as having recommended his nostrum. Borrows a good man's name and reputation and speculates upon it; this being true, is it any wonder that the true physician despises him?

In conclusion, let me say that in all ages, rules regulating the conduct of men have been necessary, and this necessity still exists, and the evil practices noticed by Dr. Simonton as occurring in the profession show that medical men still need these rules. If the old Code can be made more efficient, and the majority of the profession say revise it, I am a good enough Democrat to say, amen; but, if it is harmless and only needs enforcing, let the wise heads show us the best way to enforce it and we will be grateful.

Respectfully, W. P. Howle, M.D.

Oran, Mo., April 25, 1893.

Revision of the Code of Ethics.

To the Editor of the Journal of the American Medical Association.

Dear Sir:—Am glad that one man—Dr. Simonton—has the "nerve" to speak his *honest* convictions on the revision of the Code.

We live in a progressive country, and a physician that has not the stability, integrity, and common sense necessary to conduct himself in a respectable manner before both the public and laity "will soon hang himself with his own rope" if you will give him time. I call to mind an example in a neighboring town: The gentleman (?) is an Association man in "good standing" and the leading members simply wink at his misdeeds and then do likewise themselves. He and they will come to grief in the end but not by the *Code:* oh no, for they are strong and loud-mouthed defenders of that "time-honored document."

Getting back to the subject, I wish to emphasize Dr. Simonton's statement that the Code is a "dead letter." I personally know a member of the American Association who breaks the Code both in spirit and in letter dozens of times yearly; yet he is extremely loud in his denunciation—just like some of the writers on Code revision—of Code revision. Why does *this* man object to Code revision? Simply because he now has an advantage over honest physicians. He has no scruples in the matter, yet he knows there *are* some men who are honest enough to obey it to the letter, thereby placing themselves at a great disadvantage. What student has not seen the scheming and conniving of some of the leading college professors to get their names in public print? Who that reads the daily papers has not seen the bulletin signed by Doctors So and So, "physicians in charge." What is that but advertising, from the standpoint of the Code? We could point out instances of this kind *ad infinitum.*

Now I come to the point that all the "Journal" correspondents seem to dodge: The section on consulting with irregulars. I hold that that part of the Code prohibiting such consultations should be wholly stricken out. My reasons for this are several and conclusive, to my mind. The objection usually raised is that such consultations are doomed from the start from the very fact that one party to the consultation *is* an irregular. No matter if he—the irregular—uses identically the same remedies as ourselves, we refuse to meet him in the interest of our patient simply because he wears the brand "irregular." Right on top of this, we as regulars are very seriously taught to use *any* and *every* agent that is of benefit in the alleviation of suffering. That is the foundation of our regularity! Yet on the face of this let an irregular suggest a remedy of which we are not familiar and we at once say "it is of no account for *we* possess all that is good in medicine." The very moment we make such an assertion we become irregulars in every sense of the word. Do we not say we will use *anything* that is beneficial in the healing of the sick? The Code says we can not use anything used outside of the regular profession. "Consistency, thou art truly a jewel." A few years since at a medical gathering in California, a member got up and offered a resolution prohibiting the use of cascara sagrada, simply because its medicinal virtues were brought to light by an irregular. Reader, would you believe it? they passed that resolution. If one of that body of men was my family physician I would certainly take the advice of the maxim: *Non far mai il medico two crede.* Do any of us regulars use cascara to-day? To use a common slangy expression "I should smile and say we do."

I know an irregular who does considerable surgery and does it in an artistic—not scientific—manner, and the neighboring regulars knowing of his skill often call him in consultation for the simple reason that he can do the work better than they can. Now this being the case *i.e.*, his possession of superior skill, why *should* he not be called to give the patient the benefit of his superior knowledge? Is not the patient footing the bill? If so, is he not the one to say who should and who should not administer to his wants? That one reason alone would settle the matter in my mind. It is none of my business who the patient employs to assist me in a case so long as he pays the bill and employs a physician. Oh, but says one "you lower your dignity and you do this and do that, and its not the money involved that we look at, but its the sacrifice of principle." I hold that it *is* the "money involved" that is looked at in nine out of ten of these cases. You are just afraid that if you recognize the irregular as a physician he will divide the shekels of the community with you. I look at the money and so do you. I think it best that we should get it in a legitimate manner though, and give the patient satisfaction. Take all remuneration from the profession and see how many will desert the ranks. As for myself would be compelled to do so; yet my motives are not all financial. Far be it; for I do my best to relieve suffering and lift the fallen; yet with all that, I have money in view. Force of circumstances—poverty compel this; yet the Code says if you have a case in a family that desires an irregular in consultation you should retire, giving the patient to understand that you will have nothing to do with such an "animal," thereby losing the fee and good will of your patient, or in other words "cutting off your nose to spite your face."

As to such members of the Association as "A Kentucky Member" I have to say that he is a century behind the age in which he lives. When he talks of sending the men of whom he speaks to "roost" as he calls it, he speaks disparagingly of men who are so far above him professionally that comparison seems ridiculous. He had better get a copy of "Æsop's Fables" and hie himself to the hills of Kentucky and spend the remainder of his days studying antiquated fables from the brain of a darkey, intended for the guidance of people thousands of years ago.

The arguments of "A Conservative Member" that the Code was founded on the writings of the learned Dr. Percival and that it consists of elegant phrases and contains good advice and can do no harm (?) etc., count for nothing. We have proved that it does do harm. "Conservative Member" lays great stress on the fact that Percival was an "erudite and scholarly" man. What if he was, does that make him an

infallible guide in this day and generation? Scholarship usually denotes wisdom; but who has not seen the profound scholar whose judgment was far inferior, so far as the government of an association of men is concerned, to the progressive, active man with an educational training that hardly goes beyond the high school of his native village? From the tone of "Conservative Member's" articles that have been appearing from time to time I take it that he is capable of obeying the promptings of the mind of a gentleman—which I take him to be—without being goaded to duty by the lash of a taskmaster—Code of Ethics. If *he* can dispense with the Code—which I think he can—why can not he allow others the same privilege? He will probably answer that we have unscrupulous men in the profession that need curbing. My answer is, curb them! Do I need a set of written rules to tell me when to ignore an evil doer? I think not. We are a practical people and have no time to fritter away on superfluous nonsense. In conclusion I wish to say that *gentlemen* do not need a written Code; but if we *will* have one, let it be put in harmony with the progressive men that it is intended to instruct. It need not instruct the laity for the laity never heard of a Code. I never in my life met but one man outside of the profession that knew that there was such a document in existence. PRACTITIONER.

"The Great Patent Regulator," the Code of Ethics (No Pun).

TO THE EDITOR OF THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION:

Dear Sir:—I have just finished reading the correspondence by Dr. A. C. Simonton of San Jose, Cal., and most thoroughly agree with all he has said in regard to the revision of the Code of Ethics. But I am a little surprised that his logical mind did not mention the illogical position taken by the Code on the subject of patent rights and copyrights.

Every one knows that there is but small difference between a patent right and a copyright; morally there is no difference, one protecting the holder in the shape of an instrument, and the other in the contents of a book, consequently it should be equally derogatory to professional character for a physician to hold either. If an individual may, without committing an unprofessional act, protect his writings by a copyright, what law of morals makes it an act that is derogatory to professional character to protect his invention by a patent right? It seems to me that the bare statement of the question is against the present Code of Ethics. Yours truly, THOS. F. RUMBOLD.

San Francisco, April 26, 1893.

NECROLOGY.

DR. GEORGE CHEYNE SHATTUCK of Boston, a notable and esteemed physician of the old school, died of heart disease on March 22, 1893. His father, bearing the same name, also a physician was a resident of Boston at the time of this son's birth, about 1813. By the time the latter came of age he had gone through Harvard College, had spent a year in the study of law, and was in his last year at the medical department in Boston. At Harvard he was the classmate of Wendell Phillips, Motley, Shurtleff and others, many of them physicians of note and long life, but few of them survivors of Dr. Shattuck. He became a member of the Massachusetts Medical Society in 1836, her anniversary orator in 1866 and president in 1872. He was president of the Boston Medical Benevolent Society in 1877. His connection with the American Medical Association dates from the first convention in 1847. From 1855 to 1874 he was identified with the Harvard Medical School, in the professorates of clinical medicine and theory and practice. He was the first to hold the clinical chair in that institution, and that was less than forty years ago. He was dean of the medical school for a number of years. He was one of the visiting staff at the Massachusetts General Hospital for thirty-six years, beginning in 1849 at the time of the resignation therefrom of Dr. Oliver Wendell Holmes. He was a man who devoted much thought and time to church and educational interests. He was the founder of St. Paul's School at Concord, N. H., and gave material assistance in the upbuilding of a similar establishment at Faribault, Minn. Although a man of firm convictions in religious matters, an unfailing charity marked his dealings with men of other beliefs. He was an honorary fellow of the Philadelphia College of Physicians and of the Paris Society for Medical Observation.

DR. SAMUEL LOGAN of New Orleans, La., professor of surgery at the Tulane University, has died in his sixty-second year. He was descended from a Scottish family, resident in South Carolina during three or more generations. He was a graduate in arts and medicine of the State University at Columbia and the Charleston Medical College; taking his M.D. in the class of 1853. In 1857, he was appointed demonstrator of anatomy at his *alma mater*, and from that time continued, with only brief interruptions, a long career as medical teacher in the colleges of his native State, of Virginia and Louisiana. For three years, from 1867 to 1870 he took the subject of surgery in the New Orleans School of Medicine, which became extinct in 1870, or shortly after. In 1872 he accepted the chair of anatomy and clinical surgery in the University of Louisiana medical department, holding that professorship thirteen years. About four years ago he succeeded the late Dr. T. G. Richardson to the chair of surgery. He was visiting surgeon to the Charity Hospital. He was ex-president of the State (Louisiana) Medical Association, and ex-vice president of the American Medical Association. Dr. Logan edited Geddings' surgical text book. He was for a short time one of the editorial staff of the *New Orleans Medical Journal*. During the war, he rendered good service in the Confederate army as medical director and inspector of hospitals. His membership in the Association dates from 1869.

BOOK REVIEWS.

DISEASES OF THE SKIN, their description, pathology, diagnosis, and treatment with special reference to the skin eruptions of children. By H. RADCLIFFE CROCKER, M.D., London. Second edition, revised and enlarged with ninety-two woodcuts. Philadelphia: P. Blakiston, Son & Co.

Crocker's work has already made and sustained so enviable a reputation as one of the leading works on diseases of the skin that further eulogy would be a work of supererogation. The present revised addition is more complete and scientific than the original. Due attention has been given the newer remedies and bacteriological researches in their bearing upon dermatology. The work in short is complete and thorough in all its details. The name of the publishers is a sufficient guarantee of the quality of its make up.

HUMAN MONSTROSITIES. (Part iv). By BARTON COOKE HIRST, M.D. and GEO. A. PIERSOL, M.D. Phila.: Lea Bros. & Co.

We have before us the fourth and last part of the latest and best work on human monstrosities. This completes one of the masterpieces of American medical literature. Typographically and from an artistic standpoint, the work is unexceptionable. In this last and final volume, is presented the most complete bibliography of deratological literature, extant. No library will be complete without this magnificent work.

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MEMBERSHIP IN THE AMERICAN MEDICAL ASSOCIATION.

This is obtainable, at any time, by a member of any State or local Medical Society which is entitled to send delegates to the Association. All that is necessary is for the applicant to write to the Treasurer of the Association, Dr. Richard J. Dunglison, Lock Box 1274, Philadelphia, Pa., sending him a certificate or statement that he is in good standing in his own Society, signed by the President and Secretary of said Society, with five dollars for annual dues and subscription for THE JOURNAL. Attendance as a delegate at an annual meeting of the Association is not necessary to obtain membership. On receipt of the above amount the weekly JOURNAL of the Association will be forwarded regularly.

SATURDAY, MAY 6, 1893.

HYGIENIC MEASURES IN RELATION TO INFECTIOUS DISEASES.

The prophylactic treatment of the infectious diseases as practiced generally by public departments and institutions, by physicians, and by laymen leaves much to be desired even at this time when our knowledge concerning the mode of spreading of these diseases is so far in advance of that possessed only a few years ago. Public health authorities in various parts of the country are many years behind the time in their methods of dealing with the infectious diseases. The most flagrant violations of fundamental rules in regard to the prevention of the spread of these diseases are continually practiced in the majority of the large, general hospitals of the great cities, and if we should follow the general practitioner on his rounds among his patients we would undoubtedly meet with many evidences of neglect and omission in regard to the enforcement of proper rules and regulations in cases of infectious maladies.

It is gratifying to note the little book by NUTTALL on "Hygienic Measures in Relation to Infectious Diseases," in which is brought together the more important and necessary points of the information we possess in regard to the subjects of disinfection and prevention, as they are applied to the various infectious diseases. If we look over the pages of this book and observe the various directions and rules laid down as preventive measures and then reflect upon the actual condition of affairs as they can be best studied in the large cities, it will be seen that the general statements made at the commencement of these lines are very mild and temperate, and yet these measures referred to are recognized by all as correct and proper, and their adoption generally has been spasmodically urged upon the public authorities and institutions for some time. For instance, public institutions for disinfection should exist in every community and should be in the charge of competent, intelligent men for the purposes of properly disinfecting infectious clothing, bedding, and other articles from hospitals, and private dwellings; articles which we know positively cannot be completely disinfected without more or less elaborate apparatus in the charge of trained men, and yet in how very few instances have such necessary institutions been established. Look at the work of disinfection as carried on by the inspectors of the average health department in the large city, and then tell us what they possibly can accomplish with their crude and imperfect methods carelessly applied by ignorant persons? What precautions are observed in transferring patients with infectious diseases to hospitals? In the majority of large cities the same ambulances or police patrols are used in that instance as are used for all the purposes that such vehicles are employed, and a properly constructed, oil-painted easily disinfected special vehicle for the single object of carrying patients with infectious diseases does not exist but as an exception.

In how many hospitals can there be observed special departments for the reception and immediate care of the person and clothing of infectious disease patients? As a rule all patients are sent to the common examining room where the diphtheria and scarlet fever patients wait their turn side by side with those that are destined for the surgical and obstetrical wards; and the same wheel chair brings first a case of erysipelas or pulmonary tuberculosis, and then it goes back for one with scalp wounds or typhoid fever, perhaps, and may be all come in the same ambulance, and so on through the livelong day and night.

The dangers and shortcomings of the present absurd and inadequate public system of prevention of infectious diseases are too evident to require any particulars; they are known to the health commissioners, the city physicians, the hospital superintendents, but the system is continued month after month, and practically we have been at a standstill for some years; it requires the threatened invasion of Asiatic cholera to stir these men into activity.

If we go a step further and inquire into the extent to which disinfection and measures of prevention are carried out by the private practitioner in the various infectious diseases, it will be found that lax and imperfect methods prevail to an alarming degree. One particular disease may be mentioned which requires prompt and thorough measures for its prevention, tuberculosis, and to say that our methods in this respect are careless and loose is putting it mildly. It is our bounden duty to protect healthy individuals against this disease by every means in our power; in this case isolation is hardly ever practicable and every other method that tends to limit this dread disease should be rigidly enforced. The

sputum, the chief agent in spreading the disease must be immediately destroyed and otherwise treated according to the rules that now are familiar to all medical men. Tubercular individuals should never be permitted to sleep in the same bed with healthy persons; they should have special eating utensils which should be boiled after using; they should not be allowed to engage in work about dairies and places where the preparation of food is carried on, as for instance in restaurants. Tuberculous cattle should be slaughtered and the possible spread of the disease in stables, prevented by proper stabling. The mere mention of these rational and necessary measures of prevention of the single disease, tuberculosis, all of which are quite thoroughly described in NUTTALL'S book, will serve to bring to mind the almost criminal negligence and the astounding carelessness that prevail in this respect among medical men, institution officials, and the public in general. In how many jails, penitentiaries, insane hospitals and similar institutions are the necessary measures for the prevention of tuberculosis properly and conscientiously carried out? What have the local and State Boards of Health ever done in this particular, very important matter?

These brief and fragmentary considerations show that the hygienic measures in relation to the infectious diseases as practiced in general at the present day fall far below the requirements. The entire public service in this respect must be revolutionized from beginning to end. The health department of every city must conduct its system of disinfection upon principles that are based on a knowledge of how the various diseases are spread and of the peculiarities of the various specific infectious agents as far as they are known; the operations of these departments should be carried on by trained and intelligent persons working with modern means, and there should be scientific men attached to every such office to direct and supervise this work in which minutiæ and detail are of as great importance as in the aseptic surgical operation.

The public in general should be instructed as far and as frequently as possible in regard to the nature and mode of spreading of infectious diseases and the large penal, reformatory, and charitable institutions must be thoroughly reformed as regards their methods of dealing with such diseases as tuberculosis. The instruction in hygiene given the students in our medical colleges should be as thorough and as practical as the manifest and constantly increasing importance of this subject demands; if that were done, the Chair of Hygiene would justly become as important as any in the curriculum.

In the meantime, let us hope that sooner or later the State will change its suicidal policy and build and maintain institutes and laboratories for the study of the cure and the prevention of the infectious diseases among man and animals and thus place this country on an equal footing in that respect with the rest of the civilized world.

HEALED OR ARRESTED PULMONARY TUBERCULOSIS.

LAENNEC concludes his classical statement with reference to the possibility of cure of pulmonary tuberculosis, and the changes that occur in arrested foci, as follows: "I think that the cure of consumption ought not to be looked upon as at all impossible, in reference either to the nature of the disease, or of the organ affected." Since LAENNEC'S time observations of all kinds have accumulated showing that, in a comparatively speaking very large number of instances of pulmonary tuberculosis, arrest and even permanent cure of the destructive process ensued. Quite a number of systematic studies of the evidences of healed tuberculosis have been carried on by men in position to constantly examine a large number of bodies of individuals that died from sudden or violent causes as well as otherwise, and quite a lot of statistics bearing upon this interesting subject have accumulated during recent years. Thus VIBERT found that seventeen out of 131 persons dying from sudden or violent death whose bodies were brought to the Paris morgue, showed evidences of cured tuberculosis; SIDNEY MARTIN found forty-two cases of healed tuberculosis of the lungs in 445 post-mortem examinations; HEITLER found 789 cases of obsolete tubercle in 16,562 autopsies, *i. e.*, 4 per cent.; FOWLER found arrested pulmonary tuberculosis in 177 out of 1,943 sections at the Middlesex Hospital. Incidentally it is very curious and also interesting to note that all these last three observers found the most frequent cause of death among the instances of healed pulmonary tuberculosis to be carcinoma; the relation between carcinoma and healed tuberculosis is consequently very striking and ought to merit further clinical as well as anatomical study. H. P. LOOMIS found in 763 persons dying of a non-tubercular disease seventy-one, or over 9 per cent., which presented pulmonary changes characteristic of healed tuberculosis. These statistics abundantly indicate that, from the standpoint of the morbid anatomist, the dread disease of pulmonary tuberculosis presents itself as quite amenable to arrest and cure, at least much more frequently so than the general impression of practitioners would seem to warrant. It would be of great value if this question could be studied from the clinical side as well, so that we could learn more definitely and precisely the exact conditions and facts with reference to those in whom the disease is arrested, but this is of course almost impossible except in isolated instances, because of the length of time that inter-

venes between the clinical manifestations of the disease, and the death and autopsy.

Since LAENNEC's time it has been known that the histological processes which result in the arrest and cure of pulmonary tuberculosis are embraced in a general way under the terms fibrosis or fibroid induration; an area is formed of so-called pigment induration, scattered through which or in the center of which are calcareo-caseous masses, and this area replaces the focus of typical tubercular granulations. The walls of healed cavities consist of dense, thick, pigmented fibrous tissue, and the more or less retracted space may or may not communicate with a bronchus; usually there are pleuritic adhesions and puckering in the pleural surface of the lung over the healed tubercular district, which in the vast majority of instances is found in the apex. It was generally thought that in the majority of cases of healed tubercular areas in the lungs the tissue composing the areas may be regarded as free from tubercle bacilli; LOOMIS, however, found that in three out of twelve cases of apparently arrested tuberculosis, inoculation experiments with rabbits showed that bacilli, or more likely their spores, were still present in the tissue. This demonstration consequently shows that the disease may remain latent for an indefinite length of time, and it suggests the possibility that bacilli might escape from such areas during life and give rise to acute tubercular processes in various parts of the body which it might be justifiable under certain circumstances to trace to the apparently healed pulmonary focus. It would seem very advisable that this subject of healed or arrested pulmonary tuberculosis be studied still more in the direction indicated by LOOMIS; all foci that look like areas of healed disease should be studied experimentally by means of inoculations into suitable animals, because that is the only method of demonstrating positively the absence or presence of active, pathogenic germs. It would be interesting to know, for instance, whether the bacilli present in areas of slaty, fibroid induration are as virulent as bacilli from foci where destructive changes are going on; perhaps novel facts bearing upon the conditions that result in the arrest of the process might be obtained in this way. It would also be of great interest to study the condition of the lymphatic glands at the root of the lungs in the cases of arrested phthisis, with reference to the absence or presence of tuberculosis or tubercle bacilli, so as to show what bearing the state of affairs in the glands might have upon the development of tubercular processes in other parts of the body of those who present healed pulmonary foci, because HEITLER found in his statistical study that 106 of his 789 cases of obsolete tubercle died from tuberculosis elsewhere than in the lungs.

1893.

This year of our Lord is an eventful period in American history. The project of a great Columbian Exposition that should be twice as large and twice as imposing as any of its predecessors, was conceived and has been created. Invitations were extended to the people of all the nations of the earth to come, see and enjoy the occasion with us. These bids have been accepted, and to-day America is the World's host.

Not long ago Imperial rulers made inquiry as to whether our pretensions were fables or facts. Searchlight revelations indicated that the United States is a first class Nation, and as such might be associated with by other nations, and for the first time her diplomatic corps became accredited Embassadors.

An invitation to other nations to participate in a Naval Review on our eastern shores brought to Hampton Roads the finest and best of modern war vessels. From thence the squadron steamed to New York to pass in review before our citizen President. This review had in it the greatest concentration of naval power that has ever at any time been brought together. We suspect the representatives of other governments did not regard the American ships as second class.

This week the Columbian Exposition swings its doors and gates wide open, and if the Queen of Sheba or any of her sisters, brothers, uncles, aunts or cousins put in an appearance an opportunity will be given them to see sights, the like of which they have neither heard nor dreamed of. The Columbian Exposition will be an educational object lesson to all its visitors. More, it will be an era of date in all fields of science, art, education, religion and industry.

This being true, what may be said of medicine? That it is keeping step with collateral sciences and arts, as shown in manifest evidences of a better knowledge of many diseases, their prevention and treatment.

That there is a more general recognition of the public functions of physicians by Legislators and Governors. So that hereafter, physicians will be regarded as a potent factor in the body politic of the State and Nation.

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In educational lines it may be said that graded three and four year courses for medical students are a definite requirement in nearly all American medical colleges. Increased laboratory study and work has compelled an extended curriculum, which has obliged teachers to think and consider ways and means by which the student may be enabled to get through his course of professional study within the present extended limit. This seems to be solved in the system adopted in the new Chicago University, by which courses of study are divided into what is

designated as minors and majors of time, within which are included a certain number of recitations. A college year is a major of time in which a recitation of one hour every day in a given course is completed at the end of six months.

The major courses are subdivided into minor courses which, when complete are taken within three months, so that a student who is in arrears in a study or course has an opportunity to make up time by taking minor courses, two minors being equivalent to one major.

This system has been adopted in one of the medical schools of Chicago by which the faculty gives the regular graded course of a major, beginning in September and ending in March, and a minor beginning in March and ending in June. Thus the student receives one and one-half years' instruction within twelve months. The curriculum of the college is arranged as a four years graded course, by the system of majors and minors the classes are so subdivided that the student is enabled to complete the whole course and to take his degree at the end of three years. Within that time he has taken three major courses of six months each, and two minor courses of three months each, which together equal the fourth major course. The system is a good one, saves time and money to the ambitious and diligent student and makes of the medical professor a professional teacher.

The system paves the way for scholarships, fellowships, lectureships and special professorships. It opens avenues for endowments and benefices. We hail its coming as a fortuitous omen. Everything that is new and promises to be useful to the medical profession is desired, more, it is wanted so very much that it must be had.

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This year of Grace will also be memorable as the one in which was submitted to the American Medical Association a revised Constitution and Code of Ethics. As to the wisdom of these revisions, particularly the latter, much is being said in the pages of The Journal, in which there will be found many variations of opinion, all honestly expressed, and equally entitled to a hearing. Our own regret is that a number of writers seem to think it wisdom on their part to appear to their fellows over an anonymous signature. There is nothing in such a discussion to call forth acrimony, personal reflections or bitterness of statement. The feeling one for another should be of fraternal respect and deference, remembering that men's minds are as unlike as their faces. It is true we all have a similar education, obtained in similar colleges for similar purposes and have an identical literature. It is also true that all physicians do not live and practice their profession in similar environments, nor is it possible to always make observations through similar spectacles. In the discussion of this subject that seems to be so vital to the lives and happiness of nearly all medical men let no man forget that anathemas, personalities, charges and insinuations only count as against himself individually and the cause he advocates. It may also be well to remember that whatever may be said, there is more to be told on the other side, also that silence may be a golden salve that is shielding and healing a festering sore. The occasion should partake of the tolerance of views and lack of personal vindictiveness so singularly characteristic of the conduct of our last Presidential election campaign. Let this tolerance be exercised because of the wide diversity of opinion known to exist in the profession, among men who are equally well educated and intelligent, equally honest and honorable, equally high minded and just, and equally jealous of the good name and fame of our calling.

Because of this known wide diversity of opinion by so many men, it was deemed wise at the last meeting of the American Medical Association to appoint a committee to revise and present a new Constitution and Code of Ethics.

The revision of the Constitution has we think been made with care and good judgment. Every section and paragraph received the expressed approval of every member of the committee, who are without exception capable and conservative men. We have confidence that the Code of Ethics will come from their hands to us in a form that will be acceptable to nearly all candid and right thinking men.

It is not generally known that some of the largest societies that are in affiliation with the American Medical Association and annually send to that body their quota of delegates, do not in their constitutions or elsewhere make any recognition whatever of the Code of Ethics, or require their members to subscribe to an acceptance of the Code.

An illustration or two: The Illinois State Medical Society which has within the present year almost if not quite doubled its membership roll, does not in any way recognize the Code of Ethics or require its members to do so. Neither does the Chicago Medical Society with its nearly eight hundred members. In the same category will be found the Ramsey County Medical Society (St. Paul), with its large membership. So far as we know there is not a medical society in Chicago that in any way recognizes or makes mention of a Code of Ethics. And yet there are in Chicago and in St. Paul as able and high toned practitioners of medicine as may be found in any city. Men who are professionally pure minded, and as absolutely free from all inclinations to evil courses as may be found on the face of the earth.

These men are actively at the head of all good work in professional affairs in city and State, and are as far from being stimulators of strife and professional anarchy as the sainted FLINT, GROSS, BOWDITCH, RICHARDSON or WOOD.

Does not this condition indicate in words louder and more imperative than we can express a necessity for a revised Code in order that the American Medical Association may be consistently assimilative and have a unity of purpose that will enable it to become a greater power than it now is for the weal of American medicine.

CENTENARY OF THE DEATH OF JOHN HUNTER.—The Royal College of Surgeons of England, will celebrate a jubilee of the Fellowship on July 5, of this year, by means of a special conversation meeting. And as this is the centenary of John Hunter's death it has been arranged to commemorate the labors of brightest intellect by an exhibition of artistic and literary objects connected with him and his period, such as pictures, books, manuscripts, furniture and instruments. These will be in addition to the relics already in the possession of the College. Many possessors of Hunterian relics have offered their property for the exhibition.

ASSOCIATION NEWS.

OPHTHALMIC SECTION, AMERICAN MEDICAL ASSOCIATION.

List of papers announced for the Milwaukee meeting:

1. Pannus and its Treatment by Digestive Ferments, by J. A. Lydston, Chicago.
2. Hypertrophic Conjunctivitis and its Treatment, by Cornelius Williams, St. Paul.
3. Phlyctenular Ophthalmia, by Dudley S. Reynolds, Louisville.
4. The Total Correction of Refractive Errors, by W. F. Coleman, Chicago.
5. *a.* History of a Case of Successful Extraction of a Piece of Steel from the Vitreous by aid of the Electro-Magnet. *b.* Study of a Case of Hemorrhagic Glaucoma with Microscopic Sections, by Chas. A. Oliver, Philadelphia.
6. Glaucoma, by L. F. Love, Philadelphia.
7. Unilateral Neuro-Retinitis, with report of cases, by B. L. Milliken, Columbus, O.
8. Tobacco Amblyopia, by F. Dowling, Cincinnati.
9. Sympathetic Ophthalmia, by A. Hobby, Iowa City.
10. A Study of the Etiology of Blindness of pupils in the various State Asylums, by G. F. Keiper, Lafayette, Ind.
11. Skin grafting in Malignancy of the Eyelids and Orbit, by Flavel B. Tiffany, Kansas City.
12. Treatment of Granular Lids; Exhibition of Instruments, by C. B. Blubaugh, Parkersburg, W. Va.
13. Exostosis of the Orbit, by Robert F. Le Mond, Denver.
14. Some Rare Forms of Tumors of the Orbit and Eyelids, by J. Schneider, Milwaukee.
15. Strabismus Convergens, when and how shall operate? by S. C. Ayres, Cincinnati.
16. Rapid Dilatation of the Lachrymal Sac, by S. L. Ziegler, Philadelphia.
17. Cataract Lenses, by H. V. Würdemann, Milwaukee.
18. Albinism of Eyes, by G. M. Gould, Philadelphia.
19. Commentaries on Diseases of the Lachrymal Passages, by H. Gradle, Chicago.
20. Posterior Sclerotomy as a Preliminary to some Operations for Glaucoma, by H. Gifford, Omaha.
21. Two Cases of Brain Tumor, where Optic Neuritis was the only Positive Sign.—Autopsies, by E. P. Morrow, Canton, O.
22. The Curvilinear Reflection of Weiss as a Pro-dromal Sign of Myopia, by B. Alex. Randall, Philadelphia.
23. Intra-ocular Injections of various Antiseptics, by G. F. De Schweinitz and H. A. Hare, Philadelphia.
24. Purulent Ophthalmia from the Standpoint of its Specific Microbic Cause, by A. Hinde, Chicago.
25. Relation of Diseases of the Upper Air Passages to Diseases of the Eye, by J. G. Carpenter, Stanford, Ky.
26. A Case of Sympathetic Neuritis after Evisceration, by F. C. Hotz, Chicago.
27. Treatment of Nasal Duct Obstruction, by Casey A. Wood, Chicago.
28. *a.* The Best Form of Rod and Rotary Prism tests with a new Phorometer; *b.* Classification of Diseases of the Eye in Hospital Statistics, by E. Jackson, Philadelphia.
29. Squint and its Treatment, by J. A. Thompson, Kansas City.
30. The Artificial Ripening of immature Cataracts, by B. Bettman, Chicago.
31. Meningitis following Enucleation of the Eyeball, by S. D. Risley, Philadelphia.
32. Legislation in the United States for the Prevention of Blindness, by L. Howe, Buffalo.
33. The Results of the Use of the Electromagnet for the Extraction of Foreign Bodies, by C. Barck, Cincinnati.
34. Quiescent Foreign Bodies within the Eyeball, by W. B. Johnson, Paterson N. J.
35. Some Practical Experiences with Muscular Anomalies, by T. E. Murrell, Little Rock, Ark.
36. Persistent Spasm of the Accommodation relieved by Tenotomy of the External Recti, by A. R. Baker, Cleveland.
37. Cataract Extraction in a Negro said to be 116 years old, by F. Trester Smith and B. F. Travis, Chattanooga, Tenn.
38. The Practical Value of the Ophthalmometer in the Measuring of Astigmatism, by L. J. Lautenbach, Philadelphia.
39. Pterygium—Presentation of Instruments, by A. Blitz, Indianapolis.
40. Dendritic Keratitis, by W. H. Wilder, Chicago.
41. Congenital Symmetric Dislocation of Both Lenses Upward and Outward, by L. H. Taylor, Wilksbarre, Pa.

Papers without title promised by T. Y. Sutphen, Newark, N. J., and E. G. Gardiner, Chicago.

H. GRADLE, *Sec'y.*
65 Randolph St., Chicago.

PROGRAM—SECTION ON DERMATOLOGY.

1. The Scope of Dermatology, by L. A. Duhring, Chairman, Philadelphia, Pa.
2. Xanthoma Diabeticorum, with Microscopical Demonstrations, by S. Lustgarten, New York.
3. The Local Treatment of Psoriasis, by R. C. Longfellow, Cincinnati, Ohio.
4. Syphilis in its Relations to Herpes Progenitalis, by G. Frank Lydston, Chicago, Ill.
5. The Treatment of Pigmentations of the Skin, by John V. Shoemaker, Philadelphia, Pa.
6. Erythema Exfoliations Recurrens, with Specimens, by A. H. Ohmann-Dumesnil, St. Louis, Mo.
7. Dermatitis Herpetiformis, with Report of a Case, by John H. Duncan, St. Louis, Mo.
8. The Obliteration of Pigmentation on the Human Skin, with Experiments, by B. Merrill Ricketts, Cincinnati, Ohio.
9. On Erysipeloid, by Geo. T. Elliott, New York.
10. 1, Purpura Recurrens; 2, Points on the Nature of Eczema. By A. Ravogli, Cincinnati, Ohio.
11. Recurrent Zoster, by Joseph Grindon, St. Louis, Mo.
12. Ichthyosis in the Colored Race, and its Treatment, by Joseph W. Stickler, Lakewood, N. J.
13. On Familiar Forms of Syphilis, and the Difficulty of Diagnosis, by W. W. Tompkins, Charleston, W. Va.
14. Cases of Polymorphism in Syphilis Complicating Diagnosis, by W. F. Breakey, Ann Arbor, Mich.
15. On a Hyaline Papule Following Vaccination, by A. C. Mercer, Syracuse, N. Y.
16. Carbuncle, by W. O. Henry, Omaha, Neb.
17. Indigenous Leprosy in Louisiana, by Isadore Dyer, New Orleans, La.

18. Clinical Notes on Pemphigus, by Joseph Zeisler, Chicago, Ill.

19. An Untoward Effect of Arsenic, by Albert E. Carrier, Detroit, Mich.

20. 1, Notes on Feigned Eruptions; 2, The Use of Waxed Paper in Connection with Dermatological Practice, by L. Duncan Bulkley, New York

21. The Enlargement of the Subcutaneous Lymphatic Glands in Tertiary Syphilis, by D. W. Montgomery, San Francisco, Cal.

MISCELLANY.

SIGN YOUR NAME.

As thorough revision of the Code
Is present subject of discussion,
And incognito is the mode
Of certain ones of the profession
Who flood THE JOURNAL week by week,
With lengthy matter from their pen,
That lose the force of what they speak,
When we find we can not know the men—
Sign your name.

If not ashamed of your position,
Or of the side on which you write,
Or either of your erudition,
Or that you shall appear less bright
Than certain other of your neighbors,
Who to this theme have given thought,
And by dint of toilsome labors
The question to an issue brought—
Sign your name.

The present age in which we live,
The bold, the brave and fearless man
Has no use for "Conservative,"
Nor yet for any other plan
By which his precious head to shield,
In case he should be so unlucky
As to meet defeat upon the field,
By "A Member from Kentucky"—
Sign your name.

Whenever, then, in a discussion
You wish to enter with the throng,
Or lead the van of the profession
With argument both good and long,
Have the courage of your conviction,
Clinch the thought you would expand,
Be not timid in your position,
Stand steadfast, firm, be a man, and
Sign your name.

—W. H. HAUGHEY, M.D.

Battle Creek, Mich.

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA.—Fortieth Annual Meeting will be held in the city of Raleigh, May 9, 10 and 11, 1893. Papers to be read:

Report on Practice of Medicine, by Dr. E. M. Summerell, Mill Bridge.

Report on Surgery, by Dr. J. P. Munroe, Davidson College. "Inguinal Hernia."

Report on Obstetrics, by Dr. J. H. Marsh, Fayetteville.

Report on Gynecology, by Dr. R. H. Whitehead, Chapel Hill.

Report on Materia Medica, by Dr. Thos. Stamps, Lumber Bridge.

Report on Therapeutics, by Dr. C. E. Hilliard, Asheville.

Report on Pathology and Microscopy, by Dr. W. T. Pate, Gibson's Station.

Report on State Medicine, by Dr. S. J. Montague, Winston.

Cerebro-Spinal Meningitis, by Dr. Thos. Stamps, Lumber Bridge.

Report of Clinical Cases, by Dr. J. M. Hayes, Oxford.

Vis Naturæ et Vis Medicatrix Naturæ, by Dr. A. M. Ballard, Asheville.

Pneumonia, by Dr. J. N. Peace, Creedmore.

Appendicitis: Viewed from a Personal Standpoint, by Dr. J. W. Long, Randleman.

Diphtheria, by Dr. R. A. Patterson, Aurelian Springs.

———, by Dr. R. L. Payne, Lexington.

The Regimen and Treatment of Hyperchlohydric Dyspepsia.

(Before the Conjoint Session.)

The Necessity for Vaccination in North Carolina. Some of the Defects of the Country Asylum for the Care and Treatment of the Pauper Insane. By Dr. J. Allison Hodges, Wilmington.

The subject for the annual debate:—Rheumatism, by Dr. T. Tayloe, Washington.

DO NOT HESITATE, but at once apply for membership in the American Pharmaceutical Association. There is no initiation fee and the volume of annual proceedings alone is worth much more than the price of annual dues. Blank applications and full information can be obtained by addressing the chairman of the committee, D. H. M. Whelpley, 2342 Albion Place.

THE TWENTY-THIRD ANNUAL MEETING of the Colorado State Medical Society will be held in Denver, June 20, 21 and 22, 1893.

OFFICIAL LIST OF CHANGES in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from April 22, 1893, to April 28, 1893.

Lieut.-Col. Charles C. Byrne, Deputy Surgeon-General U. S. A., leave of absence granted is hereby extended one month.

Capt. Wm. B. Banister, Asst. Surgeon, is relieved from duty at Washington Bks., D. C., and ordered to Ft. McIntosh, Texas, for duty.

Capt. George McCreery, Asst. Surgeon, is relieved from duty at, and ordered to Ft. Sidney, Neb., for duty.

Capt. Louis S. Tesson, Asst. Surgeon, is relieved from duty at Ft. Sidney, Neb., and ordered to Jefferson Bks., Mo., for duty. Par. 14, S. O. 89, A. G. O., April 21, 1893.

Capt. Wm. O. Owen, Jr., Asst. Surgeon, is relieved from duty at Jefferson Bks., Mo., and ordered to Ft. Bayard, N. M., for duty.

Capt. Edward T. Comegys, Asst. Surgeon, is relieved from duty at Ft. Bayard, N. M., and ordered to Ft. Wadsworth, N. Y., for duty.

Capt. A. S. Polhemus, Asst. Surgeon, is relieved from duty at Ft. Monroe, Va., and ordered to report at Ft. Douglas, Utah, for duty. Par. 14, S. O. 89, A. G. O., April 21, 1893.

Capt. Wm. P. Kendall, Asst. Surgeon, is relieved from duty at. Ft. Douglas, Utah, and ordered to Willets Point, N. Y., for duty.

Capt. Wm. F. Carter, Asst. Surgeon, is relieved from duty at Willets Point, N. Y., and ordered to Ft. Sill, O. Ty., for duty.

Capt. B. D. Taylor, Asst. Surgeon, is relieved from duty at Ft. Sill, O. Ty., and ordered to Ft. Bliss, Tex. Par. 14, S. O. 89, A. G. O., April 21, 1893.

First Lieut. Francis A. Winter, Asst. Surgeon U. S. A., is relieved from duty at Ft. Wingate, N. M., and will report in person to the senior commissioner of the International Boundary Survey Commission at Yuma, A. T., for duty, relieving First Lieut. Harlan E. McVay, Asst. Surgeon. First Lieut. McVay, on being relieved by First Lieut. Winter, will report in person to the commanding officer, San Carlos, A. T., for duty at that station, relieving Capt. Paul Shillock, Asst. Surgeon. Capt. Shillock, on being relieved by First Lieut. McVay, will report in person to the commanding officer, Ft. Wingate, N. M., for duty at that post.

Capt. Marlborough C. Wyeth, Asst. Surgeon U. S. A., is granted leave of absence for one month on surgeon's certificate of disability, with permission to leave the limits of the department, to take effect when Asst. Surgeon Ware shall have returned to Ft. Supply, I. T.

Major Ezra Woodruff, Surgeon U. S. A., is hereby granted leave of absence for twenty days, to take effect after May 1, 1893.

PROMOTION.

First Lieut. Ogden Rafferty, Asst. Surgeon, to be Asst. Surgeon with the rank of Captain, from March 26, 1893, after five years' service, in conformity with the act of June 23, 1874.

OFFICIAL LIST OF CHANGES in the Medical Corps of the U. S. Navy, for the Week Ending April 29, 1893.

Medical Director J. H. Clark, ordered as President Naval Medical Examining Board.

Medical Director A. A. Hochling, detached as President Naval Medical Examining Board, and placed on waiting orders.

P. A. Surgeon L. L. von Wedekind, detached from U. S. R. S. "Wabash" and to the U. S. S. "Alliance."